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ABSTRACT

This monograph contains articles on mental health needs, experiences, and preventive social work programs in ethnic minority communities. An overview by Gwenelle Styles O'Neal reviews factors that influence the mental health of ethnic minorities and explores family and community support networks for alleviating stress. Susan Bellinger examines mental health programs and preventive activities in the workplace and discusses efforts to evaluate these programs. June Brown considers whether primary prevention, which relies on examination of social conditions and environmental intervention, can improve the design of family and child social services. Samuel O. Miller and Rita Cates discuss distinctions and linkages between physical and mental health prevention approaches, consider prevention specifically for ethnic minorities, and discuss potentials for developing and implementing preventive programs. James Leigh examines preventive programs in the educational setting, and stresses the need for social work educators, practitioners, and students to be aware of how race and racism affect mental health. David Maldonado explores prevention among the minority elderly, focusing on the special needs of this group. Finally, Samuel O. Miller stresses the need to develop social work education curricula on preventive mental health in conjunction with existing social services, and examines social work curriculum development models for mental illness prevention among ethnic minorities. (MJL)

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Primary Prevention Approaches to the Development of Mental Health Services for Ethnic Minorities: A Challenge to Social Work Education and Practice

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Foreword

The Council on Social Work Education is pleased to add *Primary Prevention Approaches to the Development of Mental Health Services for Ethnic Minorities: A Challenge to Social Work Education and Practice* to its growing list of publications on community mental health.

This monograph identifies and describes examples of mental health prevention and mental health promotion among ethnic minority individuals, families, and communities. The chapters focus on selected fields of practice–health/mental health, industry, child and family welfare, aging, and education. Attention is also given to the field practicum as a site for preventive activities. The need for curriculum development is recognized and a framework through examples is also provided.

Although prevention is viewed by many as a most advanced level of service, overcoming resistance to primary prevention remains an imperative. The Council is gratified to present this important book and anticipates that it will be a significant reference for students, faculty, and practitioners.

ARTHUR J. KATZ
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Preface

For the past 10 years the Council on Social Work Education has given major attention to program initiatives geared toward improving the educational preparation of social workers for more effective service to consumers within the community mental health system.

In 1978 the Council was awarded a grant from the National Institute of Mental Health (NIMH) to promote the development of curriculum and teaching materials on primary prevention in mental health and social work. A sourcebook, edited by Milton Nobel, was published that includes curriculum and teaching materials on primary prevention. A manual of course outlines on prevention also was prepared and disseminated widely.

In the search of the literature on primary prevention during the implementation of the prevention project, it became apparent that little attention had been given to primary prevention among

vulnerable populations, a significant number of whom are ethnic minorities of color. This monograph is a beginning effort to fill that void. It is a compilation of articles that reflect bicultural perspectives of mental health needs, experiences, and applications within ethnic minority communities. Equally important, it reaffirms the social work profession's values, which hold that people of color should have equal access to resources, services, and opportunities for the accomplishment of life tasks, the alleviation of distress, and the realization of their aspirations and values in relation to themselves, the rights of others, the general welfare, and social justice.

This book includes an overview by Gwenelle Styles O'Neal of the factors that influence the mental health of ethnic minority communities and the various resources–personal, familial, and community–that are available. She places emphasis on the strengths of ethnic minority group families, the potential of their support networks, and the resources of the community in promoting well being and alleviating stress.

Five fields of practice–the workplace, children and family services, health and mental health, aging and education–are selected for discussion because they represent major service areas in which prevention strategies may be implemented and evaluated.

Susan Bellinger examines the special nature of the world of work as a sphere for service delivery and prevention activities. She notes that increasing numbers of worksites are creating programs to address alcoholism, family changes, discrimination, and other problems that workers face. She provides examples of mental health preventive programs at the worksite and efforts to evaluate the effectiveness of the programs. June Brown addresses the question of whether primary prevention with its reliance on the examination of social conditions and appropriate environmental intervention can improve the social services design in family and children services. She suggests that primary prevention has a unique conceptual contribution to make to any serious effort to improve the accessibility and the cultural relevance of services for dependent children from minority group communities.

Rita Cates and Samuel Miller trace the historical separation of physical health from mental health preventive approaches and the current efforts to link them. They provide a perspective for defining prevention which is relevant to ethnic minority groups, cite the potential for developing preventive programs and suggest

some implication for practice. The authors place emphasis on mental health promotion rather than prevention. James Leigh focuses on the field practicum as an arena for the implementation of preventive activities. He identifies the educational setting within which preventive programs might be implemented and cites examples of preventive activities within educational settings which may be helpful. He stresses the need for social work educators, practitioners, and students to have fundamental knowledge of the effects of race, racism, and institutional racism as factors that may be causative to any potential area of concern. David Maldonado points out that the minority elderly of today are survivors of the precivil rights generation. They lived through a period of overt discrimination and segregation. Their old age is complicated by their poverty and ethnicity. However, he suggests that the resources that have been available to them in prior stages of their lives can be utilized in their old age. The task of social work education is to incorporate this wisdom, knowledge, and experience in the development of preventive content as part of the curriculum.

Samuel Miller in his summary chapter identifies the need for preventive curriculum development in social work education programs to be developed in tandem with already defined clinical and social services. He notes that there are forces within the social work education arena that resist the inclusion of preventive curriculum content within the core curriculum. He provides a framework through examples and models for curriculum development which will enhance the prevention of mental distress by promoting viable, independent, and progressive ethnic minority communities.

The development of strategies to overcome the barriers to the inclusion of preventive content will require systematic efforts on the part of social work educators, practitioners, and consumers of services. This volume is a serious attempt to address this problem. A beginning effort has been made; much remains to be accomplished.

The Council on Social Work Education gratefully acknowledges the support of the Social Work Education Branch of the National Institute of Mental Health for the grant (MH-15447) which made the Project on Prevention in Social Work Education possible and stimulated the generation of this publication.

Carl A. Scott
Associate Executive Director

1

Mental Health in Ethnic Minority Communities: An Overview

Gwenelle Styles O'Neal

The body of literature on prevention in mental health has developed considerably over the past few years. However, specific research on techniques and strategies for preventing mental ill health among vulnerable communities is lacking. General comments and/or descriptive studies regarding what does not work and what is assumed to be good for promoting positive mental health have been identified but these often lack a coherent methodology for evaluation of effectiveness.

The origins of the study of mental illness expressed concern with organic brain tissue. Advances throughout the centuries have introduced evidence that includes organic, social, cultural, psychological, biological, and environmental factors in the emotional and mental distress affecting about 10 to 15 percent of contemporary American society. Recently, emphasis has been placed on the prevalence of mental illness among low socioeconomic class members and among women, of whom a disproportionately high

number are members of ethnic minorities. Hugh Butts suggests that when federal economic policies create high inflation levels and unemployment, more fiscal resources are required and should be designated for mental health services.[1] Dear, Clark, and Clark corroborate the increased psychiatric admissions in times of economic distress.[2] Yet, despite the drastic service needs, mental health facilities have experienced financial cutbacks.

An outline of the Department of Health and Human Services' Office of Human Development Services appropriations planning states that the philosophy of the current federal administration is based on the principle that the well being of the public is primarily a responsibility of individuals, families, and the communities in which they live:

> The role of the federal government in addressing social problems is to adopt and implement national policies or programs aimed at promoting economic growth and prosperity and thereby reducing the need for social services.[3]

Recognizing the significance of economic resources on the prevalence of mental ill health, it is imperative to assess the poorer quality of treatment that many receive, and the often severe psychiatric diagnoses of many ethnic minority persons. Scrutinizing current direct service interventions for effectiveness has direct implications for potential prevention strategies, for individual and family actualization and community organization, as well as for agency productivity.

Knowledge in the mental health field has increased significantly as a result of community mental health notions, initiated in the early 1960s throughout the United States. Mental health policies mandate administrative and programmatic changes. Various constituency representatives are expected to participate in the governance system to stimulate thinking and contribute to planning for the total community. Services other than direct clinical activities are mandated. Coordination of public and private human services has been promoted. The concept of prevention is congruent with the philosophy of community mental health.

Prevention is defined on three levels: primary, secondary, and tertiary. Primary prevention, which is the focus of attention here, reflects concerns for creating strategies to promote positive mental health within a given population over a period of time by abolishing the causal factors. Secondary prevention assumes the importance

of the continuing need to define more effective treatment to reduce the disability rate in a community through early diagnosis and effective treatment. Tertiary prevention aims to reduce the rate of disability and dysfunctioning through rehabilitative approaches.[4] Social work activities traditionally have provided services at this level and further research is required for more promising rehabilitation results.

In the broadest sense, primary prevention in social work encompasses proactive planning to create mechanisms that will effect a maximum benefit in the psychological adjustment and social competence of large numbers of individuals within our communities. Primary prevention involves multifaceted strategies that can be utilized in the various fields of social work practice. Essentially, prevention activities enhance the cultural nuances and social networks which historically have operated as supportive systems for the continual adaptation to personal, familial, and community realities. Recognizing the growing significance of promoting well being and preventing distress, community support services and case management practices recommend training and service applications that coordinate resources and educate significant others in the mental health plans of specific patients, and in mental health education for the community at large.

According to the Center for Multicultural Awareness (CMA), an agency which specializes in drug abuse prevention activities, culturally relevant prevention programs involve the application of cultural lifestyles and values in program operations as well as direct minority involvement in all phases of program development.[5] The CMA goes on to explain that primary prevention efforts must have components directed at improving the quality of life for minorities by *maximizing the social, political, and economic potential of minority individuals and institutions, while ensuring the open expression of cultural diversity*[6] (their emphasis).

The methods of prevention are usually of four types: information, education, alternatives, and intervention. Sharing information among the community for understanding the problems and causes of mental distress is anticipated to have long-range influences on relieving the disproportionate rates of illness within minority communities.

The mental health problems of minority communities have been documented to be critical, so it is crucial that specific strategies for prevention be analyzed, developed and implemented. Since there is virtually no analytic and little descriptive literature

on primary prevention approaches and techniques for specific populations, this literature review is a statement of what minority and majority mental health professionals have observed and projected to be fundamental components for promoting individual and family well being in ethnic minority communities.

Areas of Concern

Statistics on the frequency of service visits indicate that among both sexes, schizophrenia, other nonpsychotic diagnoses, transitional situational disturbances, and behavior disorders of childhood and adolescence rank highest among races other than white.[7]

Generally, problem areas may be observed in all age groups–children and adolescents, adults, and the elderly. Children are especially vulnerable to mental health problems during their phases of growth in relation to the security and affection received from their parents or guardians, siblings, and other relatives. Their activities and perceived standing within the family, school, and community influence their feelings and expectations about survival. Stress and tensions within a family, regardless of its description – such as nuclear, extended, tribe, clan, single-parent, foster families, or boarding school – affect mental health and development. High unemployment rates and cuts by states in public assistance programs under the current administration's budget goals may generate further mental distress as economic conditions in many communities worsen.

The mental health of adults and the elderly, as well as that of children, may reflect genetic, organic, crisis, or developing patterns of dysfunctioning. Service or treatment intervention for problems of the various diagnoses include prescription of drugs (chemotherapy), group therapy, vocational rehabilitation, behavior modification (including shock), hypnotherapy, family therapy, and psychotherapy that may reflect a variety of schools of thought–casework, analysis, gestalt, or biofeedback.

Crisis or developing dysfunctions often occur in response to a particular or a combination of life events such as becoming a dislocated worker, being unemployed or being between jobs, disability, childbirth, separation or divorce, death, discrimination, and juvenile delinquency or criminal activities. These situations may involve or result in distress, neglect, or abuse of other family members–spouses, lovers, children, even pets. A 1980 survey reports

that transitional types of disturbances and behavior disorders of children and adolescents accounted for 27,079 of a total of 1,048,211 visits to 563 Community Mental Health Centers (CMHC) throughout the United States.[8] These statistics do not include service interventions received from friends, family, clergy, local folk healers, and others in the block, barrios, neighborhood, or town. However, referrals to CMHCs were largely from individuals, families or friends, (44%); the court, law enforcement or correctional facilities (9.2%); or from social or community agencies (9%).[9]

Minority males are reported to have the highest numbers of psychiatric admissions, commitments, and sentencing to correctional facilities.[10] The highest number of service visits to CMHCs among minority men involved alcohol disorders.[11]

Alcoholic beverages or other substances are often used to relieve tension and stress. The use of these inebriating substances among ethnic minority communities may be associated with positive mental health through their use for celebrations, occasional refreshment, and relaxation. Frequent substance use, misuse, and abuse anticipated as relief of tension, stress, worry, pain, disappointment, anger, rage, depression, and anxiety potentially can lead to addiction. Many people are not keenly aware of the medical/physical changes that may occur within one's body if alcohol is imbibed at regular and frequently high levels. Even with health information, habitual behavior is difficult to change without determination and support.

Alcoholism is reported to be at epidemic proportions in many ethnic minority communities. American Indians, in reaction to their surrounding stresses, presumably, have significantly high alcoholism and suicide rates. Blacks have been reported to reflect a high prevalence of hypertension, a probable result of the various injustices and pressures that many suffer, which is aggravated by the continued use of alcoholic beverages. Among Spanish surnamed or Spanish speaking persons, alcohol use has been associated with the concept "machismo" which encourages drinking as an indicator of manhood. Alcoholism has not been reported in significant proportions among Asian Americans. However, relatively recent observations indicate that where U.S. intervention has occurred on small islands in the Pacific and beer has been introduced to the residents, high drinking activity has ensued.

The primary ingredients contributing to mental distress among ethnic minority groups that may be aided by primary prevention are stress factors. Social environment modification,

increasing individual and family competence, and encouraging citizen participation in all aspects of community life are fundamental concepts of prevention theory that hypothesize that coping mechanisms and strength to cope can be developed through support networks.

Stress factors result from many kinds of circumstances and situations. On the job pressures, discrimination, job travel requirements, and lack of promotion opportunities may create periodic or continuing sources of anxiety. Unemployment or underemployment may stimulate pressures and feelings of inadequacy or depression. Periodically real, anticipated, or projected problems with one's mate may create tensions for either or both persons, which, if not handled honestly and timely through the participation of both partners, could lead to continuing discomfort and further problems in the long run. Other life stresses–developmental adjustments, adolescence, marriage, retirement–and environmental factors–housing, space, noise, pollution–also produce certain periods of stress.

Many stresses related to teenage pregnancies, single-parent families, or disabled family members often revolve around the additional financial and dependency responsibilities that a household must assume. The impact of verbal abuse or intermittent physical altercations that may be connected to any high stress incident may have effects many years from the immediate sources of friction. Juvenile delinquent activities have been noted to occur in families experiencing previous forms of disruption and/or severe forms of pathology.[12] Axelrod's sample noted delinquent youth from a high percentage of white families with a deceased parent. Among Black families various reasons accounted for broken homes from which the youths came.

Perez noted that the web of destructive habits, attitudes, and values that may be transmitted through family patterns of interaction can be devastating to youngsters who learn and develop around these influences.[13]

High rates of mental ill health are predicted to be probable among separated, divorced, and widowed women. Minority groups with higher proportions of female-headed families are extremely vulnerable. Resources are required to plan for the women and children who will require additional support and guidance.

The immigration of persons from Asian countries and Pacific Islands has introduced a chaotic change process for which various resources are required.[14] Most notable has been the recent im-

migration of Vietnamese refugees following the war there. Vietnamese refugees included government officials, military members, and private citizens fleeing from the perceived threat of severe communist retaliation against those who had worked for the French or American governments.[15] The experiences of these refugees include the sudden change of circumstances from life among families, friends, and generally secure employment often through disease, starvation, and exhaustion on journeys to an alien culture, language, and environment. Most of the refugees were unprepared for the immigration. However, Montero and Dieppa in their recent study indicate that over time and with public assistance, language training, job training, and family emotional supports, many immigrants have successfully resettled. The data showed clear movement toward economic self-sufficiency. They pointed out that achieving self sufficiency is, in part, a measure of the overall effectiveness of social programs in the United States.

Another study focused on the cultural displacement of a sample of Vietnamese in Denver and the stresses associated with resettlement. Family role changes, lack of religious service outlets, and other issues of acculturation were identified as pressures on the family unit. In addition, the absence of understanding mental health treatment as it is known in the United States created problems in communicating.[16]

Muhangi also documented immigration to be a source of psychiatric disorders. He pointed out that poverty is a major cause of mobility as people seek better standards of living. Mental distress and an increased incidence of alcoholism and antisocial behavior was associated with the loss of family and material support in his study of African refugees from Uganda.[17]

Stress factors have contributed to the attenuation of the traditional Black family structure and are perceived to have devastating implications for the family's vulnerability to the destructive forces of "racial colonialism". The increased divorce rate among Black families not only indicates economic realities and problems of adjustment within today's society, but also suggests that Black families may not be seeking or utilizing available mental health aids. Staples, like others, implied that the potential for Black (and other minority) survival lies in the collectivization of the community through creating and maintaining productive families.[18]

The strengths of minority group families, though not documented as well as some of the weaknesses, must be recognized and focused on. Individuals and families suffering economic discrimi-

nation and racism have borne seemingly insurmountable obstacles. Yet many have demonstrated strength and the capacity for adjustment, growth, survival, and flexibility by using the support and advice of relatives and friends. Oppressed people need respect for their abilities and achievements.[19] Strategies utilizing their strengths in working against prevailing mental and emotional strains, tensions and disease must be implemented. Their resilience is a testimony to their struggle. In fact, a recent examination of suicide indicates that Blacks are less prone to suicide than whites because of multigenerational family ties and emotional resources. The "survivor" hypothesis is illustrated by Black elderly who feel a triumph in surviving against adversity.[20] Preventive mental health care can draw on this strength.

Stress factors related to racism and discrimination in the economic marketplace ultimately must be overcome. Obviously, a task which mental health resources alone cannot accomplish, comprehensive prevention strategies must incorporate the variety of identified constituents (professionals, paraprofessionals, consumers, community agents, political representatives, and business persons) to acknowledge, support, and participate in efforts to create or enhance employment mechanisms, to strengthen and assist families in adapting to contemporary realities, and to make achievements against wasted potential and mental disease.

The prevention of mental health problems among minorities requires an acknowledgement of all the influences on their mental health and an examination of the impact these influences may have. Prevention strategies require the awareness of advances in knowledge to be used for training professionals, paraprofessionals, and consumers to participate more effectively for positive mental health; and the coordination of human service resources to meet the needs for economic independence and family development.

Resources

Contributions to positive mental health may come from corporate service agencies and from community networks. Although the family and community have always been recognized to have the major responsibility for its members, corporate entities are organized to meet certain needs of the public through particular service goals and techniques. The participation of human service agencies–educational institutions, churches, community organi-

zations, minority and majority businesses, and the communications industry– is required for a comprehensive strategy for mental health promotion. A serious partnership must be developed between staffs, consumers, and the community.

Effective strategies for minority communities suggest that traditional community approaches to problem resolution, such as talking to elders, folk healers, and clergy should be integrated with direct practice, community education, and self-help groups. These services involve different levels and forms of personal growth, political action, fundraising and advocacy. The use of information regarding information and referral services, nutritional practices, physical exercise and natural remedies, as well as motivation, discipline, therapeutic insight and more specific treatment and organizational planning are some anticipated and potential mechanisms for improving individual and community functioning.

Broad social changes and environmental modifications are likely to occur through state and federal policy-making institutions that may be influenced by local groups and their activities. Community education and anticipatory guidance are possible through housing project services, social groups, church organizations, and children and youth development programs, as well as community mental health and social welfare agencies. The success of services provided in a comfortable and relaxed setting in a housing project for Mexican Americans has been reported as an example of such strategy.[21] This variety of settings is useful for teaching children and adults to develop social competence and to modify and enhance their immediate environment.

Comas-Diaz and others comment on the significant relationship between self-concept and academic performance.[22] They encourage service planning to be sensitive to low self-concept notions caused by linguistic barriers, social factors and a lack of cultural understanding from the schools in Puerto Rican and other minority group children. The Puerto Rican concern with enriching the self-concept through cultural awareness can be expressed in family life education programs to encourage familial recognition of Puerto Rican heritage and leaders and offer aids for increasing children's academic performance.

A similar notion is expressed by Noble who suggested that young Blacks learn about and acknowledge that "we are descendants of people with remarkable spiritual strength." She encourages a revitalization in the spirit of inquiry, investigation, and restoration of a collective spirit.[23]

Mental health problems of American Indian communities require critical scrutiny and intervention regarding economic and social development independent of the reservation system imposed by the U.S. government. Many additional resources or welfare aids are available to the reservation Indian than to those who try to live in other communities. Services planning must respond to this discrepancy in human rights and to the issues generated by adjusting to alternative community life styles.

The utilization of expanded parent education for positive family mental health is critical. Family life education programs have been used successfully with low income families as well as middle class ones.[24] Several issues have been related to the type of familial communication that a child experiences. Parent education can be planned to reflect the concerns and interests of low income and other vulnerable groups and to respond to the immediate pressures of stress systems.

The Pan Asian Parent Education Project emphasizes the history and culture of the immigrant groups as the knowledge base for American service providers, educators, and community members in providing services. The potential for child abuse and neglect among recent immigrants confronted by the stresses of adjusting to life in the United States is targeted for prevention efforts.[25]

Parent education can inform parents of the importance of talking and singing to unborn infants and of developing joint plans between parents and children for disciplining highly stimulated youngsters. Future careers and specialty interests have been traced to the love, care, and attention provided to the unborn child by both parents.[26] Consistently set limits on children's behavior has been suggested as a successful means of discipline for problem teenagers. Although this concept has been around for a long time, "toughlove," as it is called in a recent article, has developed as a self-help strategy among many families.[27] Parent education can offer assistance to parents whose children and adolescents need resources for constructive activities to consume their time. Farley and Sewell reported that many delinquent Black adolescents were identified as high stimulation seekers. It was suggested that high stimulation seekers may be less likely to become delinquent if the environment provides a variety of satisfying and socially acceptable experiences.[28] Special recruitment efforts are required and must be used to advertise and interpret programs that address relevant issues of the community. Follow up of invitations to com-

munity residents to participate is useful.[29]

Prevention programs for children and adolescents can be and have been weaved into school assembly programs, club groups, and particular programs such as Upward Bound, Talent Search, Parent-Teachers Associations, and job training programs. A program sponsored by the National Technical Association, an affiliation of Black technical specialists, to introduce minority youngsters to careers in aeronautics and engineering, and the Upward Bound Program's use of leadership development and career awareness activities are examples of developmental strategies for youth. Innovative programming may also be developed for use on television networks, cable and through computer systems.

Another strategy might involve the compilation and use of resource literature lists to be distributed through community networks and service agencies regarding problem areas that children and adolescents are likely to experience during their formative years, and for adults or specific target groups as they move through developmental crises and changes. Discussion points might be associated with the recommended literature and used in the home, in discussion sessions or groups with guidance counselors, family life education groups, self-help groups, and specific mental health groups.

Consultation and education services available from CMHCs and consultants to schools and community organizations have been involved in creating prevention programs through case consultation, public information, and education. However, it has been documented that CMHC practitioners resist participating in community based programs, providing outreach services, and practicing in programs which offer alternatives to direct practice in the organization setting. This resistance is approached by in-service training and continuing education programs as well as by innovative CMHC leadership that experiments with job redesign and productivity efforts. Adapting to changing programmatic activities requires an interest or commitment to providing high quality services.

Other suggestions for effective services to minority communities emphasize the importance of the family and community networks. American Indians are described to resist the individual self-actualization concepts promoted by many traditional practitioners. Their orientation to life emphasizes their connection to the Earth and their tribesmen. Practice activities for American Indian service consumers require focusing on their desire for

mutual and clan development.

Similarly, Hispanics are described to rely on kinship ties, their church community, and less frequently, on local voluntary or municipal associations. These ties can be supported and strengthened.

The Black family network is also recognized as a source of strength and support regardless of interpretive reports to the contrary. The Asian American experience likewise recognizes the significance of family for development. Recent Vietnamese and Korean immigrants have cooperated among families to save money for establishing businesses and generating their economic bases of survival.

The strengths of families are demonstrated through sources of emotional support shared among a variety of households that encourage a strong work orientation, achievement, flexible family roles, and a strong commitment to religious values and church participation.[30] Where this healthy kinship structure operates, self-value and self-esteem are likely to be strong and grow despite negative influences and realities of racial discrimination and economic oppression.[31]

Bloom agreed with the significance of using minority community resources—the family, church, business, educational institutions, and the military—in prevention strategies.[32] He points out that the military has also played an important role in the education of young men and women from lower-class backgrounds. Plump, as cited by Solomon, emphasized the role of the church. He believes that when Blacks can connect technology with a strong belief in God, social change through self-determination will occur.[33]

Using, coordinating, and recommending the many various resources of communities is expected to contribute to the prevention of mental distress among minority groups through mutual support networks for adapting and progressing. Ultimately the political organization of vulnerable communities and their supporters as well as social action is required to influence large scale improvements that address pertinent opportunities for employment, economic development, ecological actualization, and positive mental health.

Training

Training a labor force to work against mental ill health re-

quires strategies for professionals, paraprofessionals, and consumers. Programs may be implemented through social work educational programs, continuing education departments, the consultation and education specialists of CMHCs and other agencies, and in-service training units. In recent years, the attractiveness of clinical practice or psychotherapy has occured for financial and other reasons and underlies some of the resistance to alternative service approaches. As a result, community organizing approaches have been neglected, but they, along with group work, provide useful techniques for the primary prevention of mental health problems.

Inner city, suburban, and rural areas require particular and combination approaches and activities from service agencies and from participants in the community networks. Practitioners require preparation in institutional and community approaches as well as further encouragement for sensitivity and ethnic competence. Social work education programs must examine further the requirements of geographic populations in order to determine appropriate prevention curriculum and utilize interdisciplinary and multiethnic faculty, practitioners, and students in their educational planning.

The preparation of ethnic minority doctoral level social workers for research, evaluation, administration, consultation, and other leadership roles in mental health is imperative. Programs such as the Council on Social Work Education's Ethnic Minority Doctoral Fellowship Program, those of the psychiatry, psychology, nursing and sociology associations, and the New Mexico Highlands University interdisciplinary graduate program for Mexican American researchers and evaluators are excellent examples of efforts to prepare top level ethnic minority manpower for mental health service.[34] Bicultural perspectives are making significant contributions to understanding the forces which operate for our survival. Problems that may arise for minority social work professionals, such as over identification with clients as Munoz cautions, must be identified and clarified.[35] Limitations of majority professionals should also be admitted and evaluated for understanding as students and practitioners are assisted to meet changing service needs.[36]

Miller also suggested the need to be aware of language differences (minority group English, Spanish) as well as cultural diversity. He cited a comment by Carter that sums up a goal of training practitioners to establish rapport with consumers: "with-

out genuine regard for patients' race, culture and lifestyle, rapport cannot be established."[37]

Statistics on the discipline of CMHC staff indicate that the largest numbers of staff employed are mental health workers with less than a BA and other mental health professionals (14% and 18% respectively). Social workers account for 11 percent.[38] Implications for collaborating with educators, students, and practitioners of human service or mental health backgrounds other than social work are critical. Employees often are not affiliated with any particular continuing educational program and would benefit from cooperative in-service training. Not surprisingly, community colleges account for 101 programs that include human service, mental health, and social work or social service in their program titles. A 1978 survey of new career programs at community colleges indicated a range of student enrollment from 5 to over 700 in these programs.[39] This fact suggests that community residents are interested in helping more of their community to thrive.

Evaluation

Standard forms of evaluation for prevention programs have not been developed fully. Yet performance assessment is required of program effectiveness for meeting prevention needs as well as for substantiating the need for and productivity of services in order to receive federal and local revenue support. Currently, most performance indicators require quantitative data on service activities. The National Institute of Mental Health (NIMH) prepared an Operations Management System (OMS) to be used by federally funded community mental health centers. This system delineates performance indicators into three categories – accessibility, fiscal viability, and efficiency/productivity. The OMS was developed for use under the Community Mental Health Systems Act. Some of its supporters question whether this evaluation system will be fully implemented under the present administration.

Some individual states have begun to develop their own performance assessment methods. The State of Pennsylvania has determined performance factors and needs factors to be used in its revenue allocation to counties. These factors utilize quantitative analyses of service output, costs, revenues generated, and responsiveness.[40] The State of New Jersey has developed basic indicators of accessibility and is currently developing more specific indicators for use with target populations and other areas.

Performance indicators are based on procedures from business management and generally lack any precise methodology for specifying qualitative measures of client outcome effectiveness. Empirical investigation of client outcomes is required in developing prevention strategies that contribute to the positive mental health of ethnic minority communities.

Community surveys and client evaluation forms as well as consumer participation on planning and advisory boards are recommended to establish a rapport with catchment area communities and to obtain specific need and performance assessment data. Bloom, in listing requirements for primary prevention evaluation, suggests that analysis of objective community data without recourse to any intervening interpretive judgements is the most convincing evaluation method.[41] Employment data, educational achievement, marriage and divorce statistics, and domestic violence reports are a few examples of potential sources of such data.

Evaluation and performance assessment are also required of the training programs. Pre- and post-test training program evaluations may demonstrate changes in knowledge and attitudes of administrators and staff members. Other evaluation mechanisms may document changing rates of resistance to innovative programming and community development. Performance assessment of programs is expected to further advance skills of students, practitioners, and consumers as well.

Efforts to investigate the effectiveness of social work practice have been frustrating.[42] Shulman's literature review indicates the tendency of treatment or independent variables to be vaguely defined. His methodology for evaluating practitioner effectiveness by utilizing consumer samples illustrates potential measuring procedures for prevention services in minority communities. Phillips suggests that focusing on the degree to which persons learn effective coping skills (the competence criterion) is more objective and helpful for evaluation than the therapeutic effectiveness criterion which focuses on changes in a presumed pathological process.[43]

The results of program and practice evaluation can be useful for determining a mental health agency's productivity. Studies have shown that one-to-one psychotherapy is often less effective and tends to decrease a practitioner's productivity.[44] Since the basic training of many mental health professionals has been clinical, it will be significant to assess the performance of alternative approaches for community service and agency productivity.

Summary

The preparation of a viable social work labor force to meet contemporary challenges for effective service programs to ethnic minority at-risk populations requires programmatic strategies at the training and service delivery levels. Education for primary prevention practice among ethnic minority communities must focus on utilizing their strengths, support networks, and hope in conjunction with relevant information and mental health technology to foster and maintain effective patterns for economic stability and family growth.

Implications are apparent for transactional leadership in mental health settings which emphasize organizational connections and responsibility to the community,[45] for research, and for the continual evaluation of primary as well as secondary and tertiary prevention activities. Recommendations for planning prevention services advise the utilization of cross-cultural data, international perspectives, and the infusion of ethnic minority content in undergraduate and graduate social work curricula for comprehensive illustrations of diversity and potential competence. Long-range planning must address particular mental disorder realities as well as broad environmental factors such as unemployment and the physical design of neighborhoods.

A broad spectrum of factors that affect mental health may be categorized as areas for nontraditional research and practice concerns for preparing social work practitioners. Possible areas to be explored for prevention strategies through various institutional and community resources include specific diagnoses, family growth, and economic development. Some examples for research include:

- Treating misdiagnosed clients
- Programmatic goals for emergency visitors' needs, diagnosis, and prevention
- Understanding abandonment depression in adopted and foster care children
- Helping clients understand and prevent abusive behavior
- Addressing transitional disturbances and childhood disorders
- Helping the foster child and family with adjustment problems
- Is there any real advice for decreasing the abuse of substances?

Planning and Implementation Participants for Prevention

Resource Institutions	*Prevention Activity*	*Participant or Service Provider*
Family	Primary	Family member, friend, consumer, community agent,* professional, paraprofessional
Educational Facilities: Elementary School High School Junior College College/University	Primary	Professional, paraprofessional, consumer, community agent*
Community Organizations: Youth Centers Churches Businesses Private Industry Councils Political representative offices Alumni groups Sororities Fraternities Consumer/citizen groups Self-help groups Planning bodies	Primary	Community agent,* consumer, professional, paraprofessional
Human Service Agencies: CMHCs Alcoholism Units Family Services Probation Offices Welfare Offices Hospitals Unemployment Offices Social Security Administration	Primary, Secondary and/or Tertiary	Professional, paraprofessional, consumer

*Community agent = representative of community organization able to share prevention information, organize cultural and/or educational activities which contribute to self-esteem and cooperative activity.

- Resolving marital differences before it is too late
- Practice in community housing projects
- School social work and family education; helping children at home
- Using volunteers in mental health from other human service groupings: church group participants
- Encouraging adoption of minority group children
- The impact of mental health issues on municipal planning for educational-recreational facilities
- Client outcomes and evaluation measures for prevention
- Leadership for creative prevention services
- Social action for adequate employment opportunities

A guiding factor for further research and evaluation in prevention involves the integration of resource organizations, service levels, participants, and transactional mechanisms (i.e., communicating, sharing knowledge, organizing, and motivating). The outline lists potential participants for planning and implementing community education and programmatic strategies which will aid the prevention of mental distress among vulnerable populations.

The prevention of mental and emotional distress among minority communities is a challenge. It requires the participation and cooperation of mental health organization leadership and staff, families, and community constituencies. By sharing information, working together, and drawing on technology, cultural nuances, strengths, and hope, a more vital community is likely to be realized.

Notes

1. Hugh Butts, "Economic Stress and Mental Health," *Journal of the National Medical Association*, Vol. 71 No. 4 (1979), pp. 375-79.
2. Michael Dear, Gordon Clark, and Shirley Clark, "Economic Cycles and Mental Health Care Policy: An Examination of the Macro-Context for Social Service Planning," *Social Science and Medicine* (Oxford) Vol. 13C No. 1 (1979), pp. 43-53.
3. *Federal Register*, Vol. 46, No. 220, Monday, November 16, 1981, p. 56, 365.
4. Carmen Carillo, "The Future of Prevention: Extinction or Expansion." Paper presented at National Conference on Minority Group Alcohol, Drug Abuse, and Mental Health Issues, Denver, Col., May, 1978.
5. Center for Multicultural Awareness, *A Guide to Multicultural Drug Abuse Prevention* (Arlington, Va.: Center for Multicultural Awareness, 1981), p. 1.
6. *Ibid.*
7. National Institute of Mental Health, Survey and Reports, Biometry Division, *Provisional Data on Federally Funded Community Mental Health Centers – 1977-78.* (Washington, D.C.: National Institute of Mental Health, May 1980), p. 21.

8. *Ibid.*
9. *Ibid*, p. 18.
10. Samuel O. Miller, "Strategies for Developing Culturally Sensitive Diagnoses," unpublished manuscript, p. 8.
11. NIMH, *op. cit.*, p. 21.
12. Sidney Axelrod, "Negro and White Male Institutionalized Delinquents," *American Journal of Sociology*, Vol. 57 (May 1952), pp. 569-74.
13. Joseph F. Perez, *The Family Roots of Adolescent Delinquency* (New York: Van Nostrand Reinhold Co., 1978).
14. President's Commission on Mental Health, *Task Panel Reports*, Vol. III, Appendix (Washington, D.C., U.S. Government Printing Office, 1978).
15. Darrel Montero and Ismael Dieppa, "Resettling Vietnamese Refugees: The Service Agency's Role," *Social Work*, Vol. 27 (January 1982), pp. 74-82.
16. Laurence Aylesworth, Peter G. Ossorio and Laurence T. Osaki, "Stress and Mental Health Among Vietnamese in the United States" in Asian American Social and Psychological Perspectives, Vol. II, ed. Russell Endo, Stanley Sue, and Nathaniel Wagner, (Palo Alto, Calif.: Science and Behavior Books, 1980), pp. 64-80.
17. J. Muhangi, "The Nature and Extent of Psychiatric Disorders Among African Refugees," in *The Social Consequences of Psychiatric Illness*, ed. Lee N. Robins, Paula J. Clayton, and John K. Wing (New York: Brunner/Mazael, 1980).
18. Robert Staples, "Black Family Life and Development," in *Mental Health: A Challenge to the Black Community*, ed. Lawrence Gary (Philadelphia: Dorrance and Co., 1978), pp. 73-94.
19. James E. Teele, "Strengths of Minority Groups," *Child Welfare*, June 1978, pp. 351-56.
20. Joseph Williams, "Why are Blacks Less Suicide Prone than Whites?" *The New York Times*, February 9, 1982, p. C1.
21. M.J. Philippus, "Successful and Unsuccessful Approaches to Mental Health Services for an Urban Hispanic Population," *Journal of Public Health*, Vol. 61, No. 4 (1971), pp. 820-30.
22. Lillian Comas-Diaz, Antonio Arroya, and Juan Carlos Lovelace, "Enriching Self-Concept through a Puerto Rican Cultural Awareness Program," *The Personnel and Guidance Journal*, (January 1982), pp. 306-307.
23. Jeanne Noble, "Black History: Fuel for our Future," *Essence*, January 1982, p. 124.
24. Carl A. Scott, *Recruiting Low-Income Families for Family Life Education Programs*, a report presented at the 1964 Annual Forum of National Conference on Social Welfare (New York: Child Study Association of America, 1965).
25. Pan Asian Parent Education Project, *Pan Asian Child Rearing Practices: Filipino, Japanese, Korean, Samoan, Vietnamese* (San Diego: Pan Asian Parent Education Project, 1982).
26. Thomas Verny and John Kelley, "The Secret of the Unborn Child," *Families*, February 1982, pp. 54-59.
27. Elise Piquet, "Toughlove: A New Way of Dealing with Problem Teens," *Families*, February 1982, pp. 43-46.
28. Frank Farley and Trevor Sewell, "Stimulation Seeking in Delinquent and Non-Delinquent Black Adolescents." *Criminal Justice and Behavior*, Vol. 3 (December 1976), pp. 315-20.
29. Scott, *op. cit.*
30. James W. Leigh and James W. Green, "The Structure of the Black Community: The Knowledge Base for Social Services," in *Cultural Awareness in the Human Services* ed. James W. Green (Englewood Cliffs, N.J.: Prentice-Hall, 1982), p. 106.
31. Madison Foster and Lorraine R. Perry, "Self-Valuation among Blacks" *Social Work*, Vol. 27 (January 1982), pp. 60-67.
32. Martin Bloom, "Prevention/Promotion with Minorities." Paper presented for Prevention Strategies for Healthful Living: An Interdisciplinary Conference on Primary Prevention in Health and Human Services, West Virginia University Medical Center, October, 1981.
33. Barbara Bryant Solomon, *Black Empowerment* (New York: Columbia University Press, 1978).
34. Richard R. DeBlassie and Juan N. Franco, "An Interdisciplinary Graduate Program for Mexican American Researchers-Evaluators," *American Journal of Orthopsychiatry*, Vol. 51 (October 1981), pp. 730-36.
35. John Munoz, "Difficulties of a Hispanic American Psychotherapist in Treatment of Hispanic-American Patients," *American Journal of Orthopsychiatry*, Vol. 51 (October 1981), pp. 646-53.
36. Miller, *op. cit.*, p. 40.

37. *Ibid*, p. 38.
38. NIMH, *op. cit.*
39. Edward Brawley, "Human Service Education Programs: Their Nature and Significance for Social Work," *Journal of Education for Social Work*, Vol. 17 (Fall 1981), pp. 90-97.
40. *Mental Health Bulletin*, Commonwealth of Pennsylvania, Department of Public Welfare, October 26, 1981.
41. Ricardo F. Munoz, "The Primary Prevention of Psychological Problems," *Community Mental Health Journal*, Vol. 1 (May 1976), pp. 4-15.
42. Lawrence Schulman, *Identifying, Measuring, and Teaching Helping Skills* (New York: Council on Social Work Education and Canadian Association of School of Social Work, 1981), p. 32.
43. Leslie Phillips, "The Competence Criterion for Mental Health," *Community Mental Health Journal*, Vol. 3 (Spring 1967), pp. 73-76.
44. Harold McPheeters, "Improving Productivity in Mental Health Agencies," mimeo, (Atlanta, Ga.: Southern Regional Education Board, 1979), p. 17.
45. Gwenelle M. Styles, *Leadership Orientation and Policy Implementation in Community Mental Health Centers* (DSW diss. Columbia University, 1981).

2

Mental Health Prevention In the World of Work

Susan Bellinger

There is a growing body of research that focuses on the issues of effective service delivery to people of color.[1] There is a smaller but developing body that seeks to identify and discuss prevention in the field of mental health.[2] And there is an even smaller body of information about opportunities for prevention programs and service delivery in the world of work.[3]

Given these limitations, the virtual nonexistence of materials that specifically focus on the issue of mental health prevention in the world of work for people of color is not surprising. The discussion that follows will represent an attempt to fill this gap. Of necessity, much of the following information will deal with the special nature of the world of work as a sphere for social service delivery and prevention activities.

A discussion of work and people of color must begin with a harsh reality. For sizable portions of all minority populations, the issue is not work and how the workplace can foster prevention

programs, but the fact of lack of work and the absence of any hope of ever working.

At a time when unemployment figures are reaching levels unprecedented since the Depression (10.1 million in September 1982) and when people in all parts of the country, of all ages and in most occupations, are being counted as statistical victims, the impact of unemployment on persons of color is devastating.[4] In most parts of the country, Black adult unemployment is twice that of white adults.[5] Blacks, Hispanics, Asians and other people of color, if working, are increasingly employed in "sweatshops," and in the underground economy, with no protections, no guarantees, and low pay. An even more serious concern is that the unemployment rate among teenagers is a time bomb that is ticking toward explosion. It is reported that Black male youths have an unemployment rate of over 45 percent nationally, and 60 percent or more in several urban areas.[6] Hispanic youngsters are unemployed twice as frequently as Hispanic adults. And among all teens, the unemployment rate is about twice that of adults.[7] These figures continue to rise.

This lack of jobs and job opportunities has ramifications for the country in terms of social unrest, crime, and alienation. Its impact upon those directly affected can be seen in hopelessness, increase in mental and physical illness, family breakdown, and anomie.[8] It has ramifications for the social work profession in whether it will define a role for itself in advocating for national employment programs and for social supports for those who are unemployed.

When larger and larger segments of the population do not work, have little contact with workers, and are devoid of work role models, a growing population emerges that, at some point, will be impossible to penetrate, redirect or reintegrate into the larger society. The challenge then is two-pronged: (1) developing responses to the larger community that can have an impact on those who are unemployed, and (2) tapping the resources of the world of work to maintain those who are working.

The Importance of Work

In this country, work is an activity valued by most of the population. Work can be the source of economic security, status, friendship ties, and personal definition. Think of how frequently

the response to the question of *who* you are is answered by *what* you do for a living. Work is an integral part of both the individual's and the community's life. It is often the construct that holds the individual, the family and the community together, and while it may be clear that work does not prevent mental breakdown or community dissolution, it is also clear that it can be a major factor in the maintenance of people who are being buffeted by personal and social problems. Robert L. Kahn, in discussing the role of work, says:

> Work is neither a sovereign remedy for mental illness nor a general preventive against it. Work is often stressful and sometimes pathology-inducing. Nevertheless, for many men and women, work has many positive aspects, and non-work – the lack of paid employment – is far worse. Economic fluctuations that create unemployment are stressful, both because unemployment typically implies economic deprivation and also because it implies loss of relationships and opportunity for meaningful activity.[9]

The Work Sphere

Although there have been increases in the number of minorities who have been able to move into high-paying, managerial jobs, people of color are still concentrated at the bottom of the economic ladder. They are constantly "at risk" of job loss, either because of lay-offs or because of the impact of personal problems that render them incapable of maintaining their jobs. The federal, state, and local cutbacks in social programs such as child care, senior citizen centers, and housing subsidies disproportionately affect this group. They must attempt to locate and pay for alternative resources to care for their young child or aged parent while attempting to maintain their work status.

In this social environment, the benefits of work must be viewed with ambivalence by some workers. Women, who are entering the workforce in large numbers, still earn only 59 cents on average for every dollar of a man's earnings. Minority women who traditionally are seen as wage-earners, are still concentrated in the lowest end of this spectrum.[10] The number of single-parents, especially parents of very young children, who are in the workforce is increasing, and their participation in the workforce often causes strains for the family. Workers who are emotionally or physically disabled, also struggle to fulfill the demands of the

job while receiving little support in the workplace or the community.

All of these workers – the single parent, the woman with small children, the individual with an aged parent, the emotionally or physically disabled – serve to illustrate the fact that a worker is more than a worker. He or she is a human being. These human beings are a part of a larger social system and they must respond to the demands of work, family, and community. Increasingly, work organizations are recognizing that they must be concerned about their workers across multiple dimensions:

- workers as workers
- workers as parts of families
- workers as members of communities.

This concern must be extended beyond the workplace to others who interact with workers and to other systems that interface with the workplace.

Those managing the workplace and those who represent organized workers must be concerned not only with the policies that affect workers at the specific sites, but also with the policies that affect their workers or members and their families in the larger community. Separation of work life and family life is a myth.[11] Individuals bring their life experiences to the job and carry their work experiences home, and the policies and procedures of the work organization do have an effect on what goes on in the community.

Caring about the community is viewed by business as being in its best interest. At a conference on the private sector's interest in promoting mental health, E. Robert Kinney of General Mills said that, "Obviously it is in the best interest of all business to provide help for its employees . . . as business people we must be concerned with the bottom line and it is a proven fact that healthy people make stronger contributions to their companies and communities."[12] Companies and unions are now recognizing their obligations to their constituents, and there are predictions about an increased role that companies will play in providing mental health services in the future.

> Over time, corporations have assumed more and more responsibility for the needs of their employees and the family members of those employees. In ten years' time,

> they may be the prime deliverer of all human services in the country.[13]

While the occurrence of so drastic a change is debatable, there is no question that the direction is toward worksites becoming more involved in responding to the needs of their workers. Although many persons are concerned about what these activities mean for those who are outside of the work setting (i.e., will a two-tier system of services develop with the publicly provided services becoming the inferior one?), others feel that mental health has been the domain of the public sector for too long. "It is time for the private sector to pick up its responsibilities, for mental health problems are community problems and the community, business, unions, and government should jointly develop the support services needed."[14]

The Auspice

There are about 100 million people employed in the United States. They work for countless employers in both the private and public sectors, in sites as small as a family-owned business with only a few workers or as large as the Federal government. Twenty million of these workers are organized in over 100 trade unions that traditionally have been concerned about the needs of their members in areas such as salary, safety, health, and housing. These work organizations have developed mental health prevention programs on their sites and they have encouraged the development of similar programs for their workers by professionals in the human services field. A growing trend is the employment of industrial social workers to provide these services.

Programs in place include alcoholism education, early identification of troubled workers, workshops on racism, and training for stress management. The worksite – corporate, union, or public sector – presents a tremendous opportunity to assist minority workers not only on the job, but also with the many problems they face because of their status as minorities.

Prevention Programs: Impetus and Caution

In June 1981, the Department of Health and Human Services

sponsored a landmark conference on mental health promotion/prevention at the worksite. The consensus of the over 200 participants who came from business, industry, the public sector, trade unions, and alcohol, drug and mental health agencies, was that the worksite was a most logical place for the promotion of prevention programs.[15] There was a caution, however, that "we should not expect to do more at the worksite than we are doing in society at large, for just as work and nonwork are connected, so, too, the national posture on health promotion/disease prevention influences what we can accomplish in any one area."[16]

Examples of Mental Health Prevention Programs at the Worksite

Levinson states that primary prevention is directed more frequently to total populations than to individuals, and that programming for prevention therefore must provide for the commonly experienced needs of these total populations and for identifiable target groups that require preventive intervention.[17]

The Employee Counseling/Social Service Programs that are in place at many worksites can be defined as prevention programs since they focus on a clearly identifiable target group, troubled workers or members, and since their goal is becoming more the prevention of problems rather than their treatment and rehabilitation. Counseling programs are sponsored by employers, trade unions, or joint labor-management committees, and their primary goal is job maintenance. Counseling is provided mainly for those who are referred because of deterioration in job performance, but all workers are being encouraged to utilize these services to deal with family, legal, health, or financial concerns *before* they become problems that affect the job. Responsible parties in the worksite, often alerted by counselors to the kinds of problems workers are bringing with them to their jobs, are becoming aware of the need for social changes and are responding accordingly. For example, unions and corporations are beginning to take a leading role in sponsoring child care centers for working parents. There also has been a growing recognition of the need to expand health benefits to cover all aspects of the treatment of alcoholism and mental illness. Such a change in policy removes some of the threat of job loss due to deteriorating conditions that go untreated or that are treated ineffectively.

The most common problems that plague workers as identified by Leo Perlis include:

- familial
- consumer
- health (especially alcohol and drug abuse, and stress)
- legal
- financial[18]

There can be no doubt that these are problems that affect minority workers in great numbers. Stresses placed on the family in the absence of social supports, the inadequacy of health care in minority communities, and the absence of accessible, reasonably priced legal services, all have an impact on the minority worker. The worksite presents an opportunity to respond to such needs through its counseling programs and through the related activities that are generated by the counseling program. A case example:

> Mr. Smith, a 45-year-old Black man was referred to the worksite counseling program because of a pattern of lateness. Exploration by the counselor uncovered the fact that Mr. Smith was late because his apartment was without heat and hot water. He found it difficult to get up in the morning and then had to use a neighbor's facilities to wash up.
>
> The counselor identified the appropriate city agencies for Mr. Smith, made a few telephone calls to assist him, and also connected Mr. Smith with a Tenants Rights group which is now helping the residents of the building organize to demand needed services.
>
> Because the counselor was aware that several other workers had come in with housing complaints, she arranged a series of workshops on housing rights to give workers information and the tools to change their living conditions.

Alcoholism Programs

A special category of counseling programs in the workplace is the Alcohol Abuse or Employee Assistance Program. These programs have proliferated, and, according to the National Institute of Alcohol Abuse and Alcoholism (NIAAA), their numbers have

increased from less than 500 in 1974 to 5,000 in 1980.[19] Alcoholism and alcohol abuse cause serious problems in the workplace. Alcoholism is a serious concern to those who focus on the minority worker, since alcoholism is reported to be at epidemic proportions in many minority communities.[20] In response to the alcoholism problem, those in the worksites have not only established assistance programs, but they have launched education and information programs to alert workers to the potential dangers of alcohol abuse.

Several worksites are also involved in attempting to prevent alcohol problems by reviewing their organizational structure to ascertain whether they are maintaining a "culture of drinking" which encourages alcohol intake (for example, worksites where the norm is to allow coworkers to "cover-up" for the worker with the drinking problem).[21] When worksites determine that they are fostering negative patterns in relation to drinking, they can attempt to use the resources of the organization to intervene by providing alternate activities for workers during lunch hour and removing liquor from the dining rooms, and the resources of the workers to offer support by sponsoring self-help groups.

Education Programs

Training sessions and lectures are being offered at many worksites on topics of family life such as parenting, dual-career families, coping with a troubled teenager, and retirement planning; on stress and stress management; and on human relations issues, such as sexism, racism, and affirmative action. Such programs are particularly relevant to minority workers.

Historically, families have been a source of strength for minority populations. Members of the extended family could be counted on to step in to provide child care, financial assistance, and personal support. But these families have suffered under the impact of changing standards, values, and demands, and many find it difficult to serve their previous functions. Family life education programs such as those offered in the worksite, may serve to refocus family expectations and may point out ways to reinforce the residual strength of the family. They also encourage workers to acknowledge that they have family problems but that these problems are solvable.

By the same token, programs that focus on affirmative action

and give the message that the worksite is committed to the equal treatment of all its workers provide an improved context within which minorities can function. Specific programs and open support *can* reduce the effects of discrimination and can give minorities hope for job maintenance, upward mobility, and reduced stress.

These examples suggest that there are numerous opportunities for developing prevention programs for minority populations in the world of work. A start has been made in the increasing numbers of worksites that are accepting their responsibility for their employees or members, are hiring social workers to provide services, and are expanding their area of concern from the individual worker to the worker, his or her family, and the community. The challenge ahead lies in extending the number of those who have the interest and resolve to accept responsibility for the health and well being of their workers. And the challenge lies in training social workers who understand the world of work, who can relate to minority populations, and who have visions beyond the provision of individual services.

Schools of social work must develop additional courses that provide information on the history and structure of businesses and unions, they must integrate knowledge about workers in general and minority workers in particular into their course content, and they must introduce or reinforce courses on advocacy, program planning, community organizing, and research/evaluation. If there is a danger to the potential for developing prevention programs in and through the worksite, it is that social workers will miss their opportunity and will become the deliverers of service to "troubled" workers but they will not be the developers of services and programs to prevent troubled workers, families, and communities.

Other Resources in the World of Work

The elements of the workplace, especially the trade union, contain another resource that has not yet been discussed. That resource is *the worker.*

Union members pride themselves on the fact that members take care of each other. Although the primary concern of the union is the contract that protects collective bargaining, salaries, and fringe benefits, there is also a realization that there must be

concern for the off-the-job problems of the members.[22] The concept of mutual aid is a cornerstone of the trade union movement and thus it becomes a natural way for people to offer and receive help. Workers are in unions out of a belief that individuals can come together to help each other and to share in the benefits of such an arrangement.[23] A member might lend a sympathetic ear and direction to a father and fellow member who is concerned that his son is using drugs. Alternatively, he or she could organize a social action class to encourage members to become politically active. Union members have joined together to demand changes in housing laws, to rally against social security cuts, or to get a clinic to expand its evening hours.

A union's survival is based on how effectively it can build membership loyalty, and one of the most effective ways to do this is through its mutual aid groups. These informal systems are often the most effective vehicles for responding to members' needs.

In recognition of this fact, many professionals who provide mental health services in or to the workplace also offer training to members, union counselors, shop stewards, and union representatives. These individuals are either natural or designated "help givers" to the general membership.[24]

Mutual aid groups are found less frequently in the corporate workplace and in those sites where the workforce is unorganized. They do, however, exist. For example, women or minorities who enter the workplace under affirmative action plans, often join together to offer each other support, to reduce feelings of isolation, and to share information. Professional social workers who provide services in the worksite have helped form, or encouraged the formation of groups of divorcees, workers who want to stop smoking, or alcoholics in treatment. Outside of the union auspice, there is often hesitancy about coming together in the workplace because there is fear that a worker who joins such a group may be labeled or viewed negatively.

In any work setting, so much of the working day is spent with coworkers that it is natural that friendship and support groups would emerge. As the minority family undergoes change and family members move away from each other, as neighborhoods change, and as the church plays less of a part in the daily lives of most minority adults, the work group becomes more and more important. Work groups may be even more important to minority workers, most of whom are used to being a part of a "family" (defined as kin or non-kin) that offers comradery and support.

The work group is especially important to minority workers because its members can ease the pressures of work by:

- sharing knowledge about the job with newer, untrained entrants
- providing protection from job demands and demanding bosses
- offering social support both on and off the job, particularly for minority group members working in largely white institutions and organizations. (The insecurity that minorities often feel in these settings is frequently underestimated.)

Social workers need to recognize that workers are an important resource in the workplace. Strategies developed for operating effectively in the work sphere must include the encouragement of natural work groups and mutual aid systems, and the integration of professional services within these already operating systems.

Evaluation

The need to develop a pertinent methodology that can be utilized to evaluate primary prevention programs has been identified and discussed.[25] There are few who would deny that without vigorous attempts to define clearly the substance of prevention and identify the ways in which prevention programs make a difference and how, support for such efforts will gradually erode and what will be left will be an idea and a belief without the necessary means to act on either. Evaluation of prevention programs is viewed as a difficult task because the target populations are often broadly defined, there is often little ability to set controls in terms of movement and involvement of the groups, and the "hoped for" outcomes are usually multiple.

In the world of work, where service programs are relatively new and where evaluation mechanisms are just being instituted to determine what works, why, and in what ways, there has been little consideration of evaluating prevention programs because there are few recognized instances of such activity.

The majority of worksite mental health/social services programs are focused on the individual worker who is in danger of losing his or her job. Services are provided to prevent this from

happening. Because of the attempts to destigmatize these services, the concerns about confidentiality and the newness of the programs, the evaluation process has often been given low priority. Practitioners have relied on devices such as aggregate data on utilization rates, individual success stories, "a positive grapevine," and worker/client satisfaction forms to determine whether the programs were fulfilling their goals.

Most practitioners have responded to a worksite's request for harder data or cost-benefit analyses by repeating the premise that "If you believe that work is important to most people; if you believe that most people want to work; if you believe that a variety of problems can get in the way of a worker performing on the job and that the elimination or reduction of these problems will allow workers to function more effectively, then you also have to believe that service programs for workers are effective."

Such an answer has worked in the past, but increasingly practitioners recognize that they must attempt to ask and answer more rigorous questions. This is particularly true as programs are being expanded beyond direct service to include consultation, training, educational/informational activities, support groups, and prevention.

Increasing numbers of programs are already reviewing and evaluating their programs in terms of outcome using indicators such as reduction in absenteeism, disability claims, on-the-job accidents, use of sick time, interpersonal disputes, and improvement in job performance.[26] Utilization rates continue to be a good indicator of at least one goal – the acceptance of a service program by workers.

Since much of what is responded to within the worksite and in the surrounding environs cannot be reduced to simple cause and effect, it is difficult to evaluate it in this manner. It may well be that when viewing prevention programs in the industrial arena, the key issue is not the need to prove the *effectiveness* of the programs but rather it is the need to *identify* the ways in which the programs are providing support and opportunities for change in the wider community. If one believes, as is the premise here, that work and the world of work can be a powerful mental health prevention program, the items on the evaluation/research agenda must by needs be the identification of ways to:

- broaden support for a full employment program;
- encourage national and corporate endeavors that will reach

out to and employ the unemployed and the "unemployable";
- garner support for realistic job training activities that allow more minorities to enter the world of work to perform meaningful tasks;
- establish linkages between minority communities and those with economic power to develop jobs within these communities;
- identify the specific positive connections between work and social stability, and find ways to translate these findings into programmatic responses;
- develop more resources in the world of work, and identify the best way to make these accessible and acceptable to minority workers; and
- spell out in new, meaningful ways to those in the world of work the benefits of taking responsibility for certain aspects of their workers' lives and their community's well being.

The call to action for research and evaluation is first a call to awareness of the potential of the worksite to engage in prevention programs. It is then a call to acceptance of the important role that work (and its absence) plays in the lives of minorities. It is a call to education of social workers to understand the larger issues of work, family, and society. It is a call for policy analysis that will place work high on the national agenda and program implementation that will encourage resource utilization to maintain people at work.

As with most prevention programs, it may be *difficult* to prove the direct, observable outcome of one's efforts but a case *can* be made for the role work can play in the reduction of individual mental health problems and the maintenance of family and community stability. The challenge is to tap the resources effectively and track the results so that replication and expansion become possible.

The Uncompleted Agenda

The world of work offers the promise of economic security, improved status, skill development, and increased feelings of self-worth for the individual. It has yet to fulfill that promise to those

outside who wish to enter the world of work and can find no way in.

For those who do enter the world of work, a range of possibilities exists. These possibilities include participating in efforts that can enhance one's personal and work life. The workplace can be an important source of strength and support during times of stress and emotional turmoil.

Work organizations can also play vital roles in supporting individuals and revitalizing communities through targeted efforts, such as sponsoring housing and supporting direct services programs in the community. And social workers can play a role in being vigilant in making sure that all parties strive to reach their fullest potential.

Notes

1. See *Social Casework*, Vol. 57 (March 1976), and *Social Work*, Vol. 27 (January 1982) for examples of this material.

2. See writings such as *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen E. Goldston (Washington, D.C.: U.S. Government Printing Office, 1977); and Martin Bloom, *Primary Prevention: The Possible Science* (Englewood Cliffs, N.J., Prentice-Hall, 1981).

3. See for example, Sheila Akabas and Paul Kurzman, eds., *Work, Workers and Work Organizations* (Englewood Cliffs, N.J.: Prentice-Hall, 1982); Paul Kurzman and Sheila Akabas, "Industrial Social Work As An Arena for Practice," *Social Work*, Vol. 26 (January 1981), pp. 52-60; and Robert Nolan, *Industrial Mental Health and Employee Counseling* (New York: Behavioral Publications, 1973).

4. Bureau of Labor Statistics, *Handbook of Basic Economic Figures* (Washington, D.C.: U.S. Government Printing Office, April, 1982).

5. See the *Miami Herald*, May 25, 1980, p. 1, for discussion of one such location.

6. *Black Enterprise*, Vol. 12 (June 1982), p. 71. CBS Television presented a special documentary on the employment problems of Black teens in Gary, Indiana.

7. Harriette McAdoo, "Demographic Trends for People of Color," *Social Work*, Vol. 27 (January 1982), p. 19.

8. Harvey Brenner, *Mental Illness and the Economy* (Cambridge, Mass.: Harvard University Press, 1973); and Louis A. Ferman and Jeanne P. Gordus, eds., *Mental Health and the Economy* (Kalamazoo, Mich.: The W. E. Upjohn Institute for Employment Research, December 1979).

9. Robert L. Kahn, "Economic Changes and Mental Illness: A Commentary," in Ferman and Godus, *ibid.*, p. 232.

10. *Data Track and Women in the Labor Force* (Washington, D.C.: American Council of Life Insurance, 1980).

11. Rosabeth Moss Kanter, *Work and Family in the United States: A Critical Review and Agenda for Research and Policy* (New York: Russell Sage Foundation, 1977), p. 8.

12. E. Robert Kinney, Chairman of the Board and Chief Executive Officer, General Mills, Inc., speech at the General Mills American Family Forum on "Private Sector Initiatives to Promote Mental Health," Washington, D.C., May 13, 1980.

13. R. Egdahl, D. Walsh, and W. Goldbeck, eds., *Mental Wellness Programs for Employees* (New York: Springer-Verlag, 1980), p. 7.

14. Virginia Dayton, Chairperson of the Employee Resources Task Force, United Way of Minneapolis, speech at General Mills Forum, *op. cit*

15. *Proceedings*, Conference on Alcohol, Drug Abuse and Mental Health Promotion/Prevention at the Worksite (Alcohol, Drug Abuse, Mental Health Administration, Public Health Service, U.S. Department of Health and Human Services, June 1981).

16. *Ibid.*, Eli Ginzberg, pp. 1-2.

17. Risha Levinson, "Developmental Provision: A Prevention-Oriented Conception Teaching Social Policy," *Primary Prevention In Mental Health and Social Work* (New York: Council on Social Work Education, 1981), p. 49.

18. Leo Perlis, "The Human Contract in the Organized Workplace," *Social Thought*, Winter 1977, pp. 31-32.

19. Nancy Kolben, *Human Services Programs – Employer and Union Sponsored* (New York: Community Council of Greater New York, January, 1982).

20. Gwenelle Styles O'Neal, "Mental Health Prevention for Ethnic Minority Communities: An Overview," (Draft for current monograph), p. 6.

21. For a more extensive discussion of this issue, see Michelle Fine, Sheila H. Akabas and Susan Bellinger, "Cultures of Drinking – A Worksite Perspective," Vol. 27 (September 1982) pp. 436-440.

22. See Ruth Antoniades and Susan Bellinger, "Organized Worksites: A Help or Hindrance in the Delivery of Social Work Services in and to the Workplace," (paper written for the Industrial Social Work Symposium in Toronto, Canada, September 1981) for examples of mutual aid activities. Accepted for publication as a special edition on work by the University of Toronto or in *Social Casework*.

23. Leo Perlis, *op. cit.*

24. See Sheila H. Akabas and Susan Bellinger, "Programming Mental Health Care for the World of Work," *Mental Health*, Vol. 61 (Spring 1977), pp. 4-8.

25. See Helen Reinherz, "Evaluating Programs of Primary Prevention: How Can We Know If They Make a Difference," *Primary Prevention In Mental Health and Social Work* (New York: Council on Social Work Education, 1979), pp. 54-63.

26. As an example, see E. Gaeta, R. Lynn, and L. Grey, "AT&T Looks at Program Evaluation," *EAP Digest*, Vol. 2, No. 4 (May/June 1982), pp. 22-31.

3

Primary Prevention: A Concept Whose Time Has Come for Improving The Cultural-Relevance of Family and Children's Services in Ethnic-Minority Communities

June Brown

Problem

While family services represent a resource to some families as they experience certain kinds of family difficulties, child welfare services have developed in much broader scope as society's way of safeguarding the lives, the physical well being, and, ideally, the welfare of dependent children. However, in this context, the term "dependent child" does not refer to the dependence of immaturity that is common to all children. Rather, the children who are served by child welfare either are bereft of family or are thought to be living in homes and with parents whose care and treatment of them is seriously inadequate or abusive. This limited view of the public responsibility for children seems to derive from the fact that traditionally Americans have regarded the family as a private realm. Therefore, the notion of supportive outreach to families to promote their ability to function is in conflict with the basic American ethic of individualism.

Child Welfare Services: A Residual System

Consequently, with child welfare's early and on-going mission focused on family breakdown, child dependency, and protective intervention, this emphasis has set a pattern of serving children apart from their families. The intent of child protection notwithstanding, child welfare services have evolved as a residual and a seriously stigmatized service. With few exceptions, child welfare assistance mobilizes only after the facts of serious family dysfunction and child endangerment are ascertained and when no solution offered is a satisfactory one. Services are often perceived as aggravating family problems and fostering unwise separations of families. In short, more than a century after the public conscience was provoked to consider that safeguarding the lives and well being of children and youth is a primary obligation of a progressive society, child welfare remains a residual system, and many children are being badly served.

These problems notwithstanding, social work theorists and practitioners, as well as physicians, lawyers, and social scientists whose professional interests have remained with children and their welfare, have continued their efforts to improve the field's capacity to serve. Problems in service delivery have been identified and alternative measures proposed. In the context of the call for reform of the child welfare concept as well as its operations, two issues raised over the past two decades are germane to the topics of this monograph and this paper. First is the articulation and pursuit of the notion that preventive goals and means are as important as treatment and protective services in working with problems of family life and functioning as well as with concerns about child development and well being. Presently, prevention is being urged in relation to child neglect and abuse as well as in regard to the unwarranted separation of children from their families in favor of out-of-home care placements. A related issue has been the legal trend toward preventing the inappropriate entry of children and youth into the juvenile justice system for "status" offenses or for first or minor violations. This change, in turn, has presented family and children's agencies with a new and "unfamiliar" population to be served.

The second issue relates to the needs and well being of the nation's minority group children. The aggressive concern for the unmet needs of dependent children who were Black or from other racial minority backgrounds was, in fact, one facet of the

larger civil rights struggle of the 1960s, when Black Americans began to challenge institutional racism and pioneered the movement to achieve basic rights of citizenship, to exercise equal claim on the society's opportunity systems, and to have access to basic benefits and resources – including social services. The latter claim subjected social welfare, social work, social work education, and the social services to close scrutiny and to criticism and calls for reform. The criticism was based on the perception that while the social welfare establishment had significant impact on minority communities, it was rarely in constructive communication and interaction with them. Consequently, since the 1960s, persons of color have made their position clear: In order for social services to be useful and acceptable to minority populations, they must incorporate the minority perspective.

Calls for Reform

THE MINORITY PERSPECTIVE

As a part of the civil rights thrust, social workers from the several racial minorities began to push for the inclusion of ethnic content in the social work curriculum. The goal was to have the full spectrum of social workers incorporate cultural awareness of the various ethnic minority populations into the professional perspective. To be culturally aware is to understand that ethnic minorities live in two worlds, which Chestang has conceptualized as the sustaining and the nurturing environments.[1] The sustaining environment is the larger society which controls the economic resources of education, employment, and opportunity systems; and by the mechanisms of discrimination and institutionalized disadvantage, it has subjected minority collectives to an undue share of the ravages of poverty, injustice, and powerlessness. Paralleling this, however, are the nurturing environments of family and community which, with their traditions and values, significant relationships, and natural support systems – including extended kin and tribes – support individuals, (adults as well as children), as they contend with the minority condition as a part of their efforts to grow and develop and manage the responsibilities of every day living.

As racial minority communities argued for change, the first objective was to fill the void of quality, minority controlled, pro-

fessional social work services within the boundaries of or in areas of easy access to minority communities. The complementary goal was that such services should be relevant and responsive to the social realities with which minority persons live and provide full understanding of and respect accorded to their cultural values and traditions. In short, the minority perspective argued, early on, for an ecological approach to need or problem assessment and to the development of programs and intervention strategies that recognize the environmental stresses experienced by these populations and will be culturally appropriate for them. The final point to be made in explicating the minority perspective is that among all of the groups – Asian, Black, Hispanic, and Native American – the family is regarded as the cornerstone of the culture and its importance is foremost in the expressed value systems.

THE FAMILY PERSPECTIVE

The importance of the family for personal and social well being, which is highly regarded in the value stance of minority communities, is reinforced by a body of research that has developed and grown in importance over the past 30 years.[2] Studies have provided important insights into the internal workings of families, and the research has given us a better understanding of the impact of family life on child development and of the significance of the social environment for a family's ability to function and to cope. Consequently, it is apparent that any efforts to lessen the estrangement between minority group communities and child welfare services, and to place general child welfare practice abreast of what is now known about child-family-community interdependencies, must include a plan for reform.

The reform thrust for this service system should incorporate a commitment to support the energies and efforts of minority families as they struggle to meet the responsibilities of daily living and child care in social environments that all too often impose great odds. After having accepted the family as the focus of service, a planful and appropriate approach to reform in the interest of improving services to minority children would imply: the development of ethnic-sensitive programs; the appointment of ethnically competent, professional social work staff at administrative and direct service levels; and the acceptance of the concept of program accountability to the communities that are served as well as to the general society. Ultimately, any plan to build child welfare as a primary service must include the same degree of com-

mitment and funding for serving children in their own homes, with preventive as well as restorative goals, as has been given traditionally to protective and placement services.

THE REFORM PERSPECTIVE

The call for reform does not fail to appreciate the program innovations of individual agencies nor does it disregard the changes that have come about in response to the charge that was made a decade ago that "The system of child welfare services in this country is failing black children"[3] and, by implication, failing minority children as a group. It is important to note, however, that by and large the changes have not reflected the minority perspective; rather, they have remained in the mold of traditional practice. The primary objective has been to enhance adoption opportunity for minority children through such innovations as aggressive recruitment of adoptive families in minority communities, single parent adoption, transracial adoption (itself a challenged concept), adoption exchanges, and adoption subsidy. Certainly, adoption and strategies to facilitate adoption will always be a valued and essential component of a comprehensive model of child welfare services. However, from the minority perspective, adoption cannot be viewed as a first option. It is better placed as a complementary service to be used for those children whose families are absent or who cannot be helped to rebuild and to function.[4] Indeed, minority communities have argued consistently for social services that will be primarily committed to supporting and sustaining families, thereby preventing the need for family separation whenever possible.

The call for reform, therefore, does propose the incorporation of what has been learned from the demonstrations and experiences of a cadre of communities and agencies that have pursued one or both of two approaches in program planning and service delivery. One approach has been the development of ethnically-sensitive services for given populations of minority group children in the life context of family, school, and neighborhood.[5] The other reflects the vigilance and flexibility of those agencies that have adapted their programs to include services to children in their own homes in the effort to respond, in a useful way, to the changing times.[6] These times find Americans of all backgrounds more vulnerable than ever before to problems of family dysfunction and breakdown which bear such terrible con-

sequences for children and require effective helping-treatment resources.

The call for reform is a compelling one in that it derives from a sense that develops from literature reviews, from observations, and from the all too frequent reports of "neglect and abuse" of children by the child care system itself.[7] It is a sense that strongly suggests that exemplary services, for families and children in general, and for minority families and children in particular, are in notably scarce supply.

Child Welfare Policy in American Society

SOCIAL RESPONSIBILITY FOR CHILDREN

The late 19th and early 20th centuries marked the beginning of a new social order for Americans – modern industrialism. Among the many trends that characterize our century has been the change in the status of children. Their social standing was revised from chattle to person, and childhood was redefined as a time of preparation for independent and productive adulthood. The young would, therefore, require a special quality of protection, care, experiences, and opportunities in order to develop and mature in line with the expectations of a "progressing" society.

A major agenda item of progressive reform was to develop and activate a policy of social responsibility for the purposes of liberating young children from toil and danger in the mills and factories, the essential step in providing them new and better life chances,[8] and of safeguarding the wellbeing of minors when their parents fail. While the goals were well placed and the achievements significant, the benefits gained were never equitably applied. The literature of the era reveals a notable scarcity of concern for the plight of Black children trapped in the neoslavery of sharecropping; for American Indian children subjected to many forms of what Hagan called "acculturation under duress;"[9] or for Hispanic and sometimes Asian children working in the fields of California and the Southwest. Although the process involved conflict, resistance, and absence of concern for the particular conditions and needs of major segments of the child population, early 20th century Americans were about the business of enacting laws and policies to protect and promote the welfare of minors. This included the emergence of a genre of social services whose purpose

was to protect children from neglect and harm in their own homes and to plan for their care and supervision in out-of-home placement.

PUBLIC SOCIAL SERVICES FOR CHILDREN

Direct services for children, initially a private agencies endeavor, remained the concern of philanthrophy until 1935, when the Social Security Act's Title V initiated the development of "public welfare services for the protection and care of dependent and neglected children and children in danger of becoming delinquent." The new public child welfare system developed within the perimeters of funding limits and local interest until 1962 when the policy was amended to expand and improve services. With the provision of increased federal funds, the several states were helped and encouraged to make children's protective services available in all political subdivisions by July 1, 1975. The nation was attuned to the emerging specter of child abuse in its midst, and, as expected, the new monies were a catalyst for a notable increase in nationwide child protective services. However, in the years that followed, the system has been besieged by problems: the sustained increase in the incidence of child endangerment; delayed placements; poor placements; the uncertain status of children in the foster care 'limbo'; the perennial dilemma posed by limited adoption opportunity, especially for minority group children; and the harsh implications of all these things for children's health, development, and well being. In this troubled context, the caseload has increased markedly!

The most recent change in the public policy for children's services was the enactment of the Adoption Assistance and Child Welfare Act of 1980 – PL 96-272.[10] In Congressional debate for five years prior to its passage, the new law appeared to represent a serious effort on the part of the Congress to address the fundamental problems of a key social system, which in its most functional form could be a valuable and valued resource for the nation's families. In prescribing a national standard for child welfare services – which includes preventive services as well as protective intervention, placement, and permanancy planning services – PL 96-272 embodies the potential for shifting the child welfare system, which is now an interdependent complement of public and private agencies, from its historic residualism toward more primary objectives.

Proposal

According to the new law, child welfare services should include several purposes, among them: (1) to promote the welfare of all children, (2) to prevent (or assist with) problems which may result in child endangerment; and (3) to prevent unnecessary separation of children from their families, that is, "to prevent the break up of the family where the prevention of child removal is desirable and possible."[11] While prevention is prescribed in all three purposes, the latter purpose implies acknowledgment of the boundaries and limitations of preventive intervention. It would follow then that the policy was drawn to require a continuum that includes prevention, early problem-solving, protective placement, and permanency planning services. Finally, in limited recognition of the need for culturally sensitive services, there is provision in the law for direct funding to Indian Tribal Councils, enabling them to develop child welfare programs within tribal communities.[12]

The formation and enactment of a public policy is a legislative function; its implementation is often a professional one. In the human services, experience has taught us well that success is influenced by many things: by the relevance of the policy's purposes to the problem; by the adequacy of the resources, including personnel, available to support its implementation; and by the effectiveness with which purposes are translated into program and practice. In other words, PL 96-272 prescribes that "reasonable efforts shall be made to prevent or eliminate the need for removal of the child from his home" as the first goal of child welfare services.[13] The task remains, however, to conceptualize and implement preventive practice properly as the first level of a service continuum in a contemporary concept of family and children's services, that will also include services to help resolve family problems, temporary out-of-home care services, family reunification services and when required services to provide permanent alternative arrangements, including adoption and planned long-term foster care.[14]

PRIMARY PREVENTION: AN ASPIRING CONCEPT

The public health discipline was the first to study the implications of prevention for the human services, and it formulated the now well-known construct of three levels of preventive intervention. In time, discussions of the potential for preventive practice began to appear in the community mental health and social

work literatures. The secondary and tertiary levels of prevention are compatible with the treatment/rehabilitation functions of the mental health services. However, primary prevention – which is closest to the lay conception of prevention: "to keep from happening; to make impossible by prior action; to hinder"[15] – has proved troublesome to translate from an article of faith and goal into useful practice principles.

Skeptics have disputed the feasibility of prevention practice. They have based their position on the fact that mental disorders have no known single cause, and they have, therefore, argued that this lack of knowledge of etiology of most psychological disabilities creates uncertainty about appropriate targets and goals for preventive intervention. Given this theoretical void, even the proponents of prevention agree that no widely acceptable technology has developed for preventing psychopathology. According to DeWilde, although options have been proposed, and preventive programs do exist, no treatment principles have emerged from vigorous evaluation.[16] Proponents, however, have moved from the debate to urge conceptualization of a systematic approach to theory building for preventive practice.[17]

Bloom makes the point that although the history of remediation of mental illness has been frustrating, treatment services still have the mandate to "try" to be helpful, and he proposes that in the interest of reducing the incidence of disorders and promoting health, prevention should receive the same sanction to try.[18] In order, then, to establish a base for systematic theory building for preventive practice, Munoz says that although we lack knowledge of etiology of psychological disturbances, we do have theories of human development and behavior which will provide the assumptions with which to begin to develop hypotheses and study the issues.[19] Furthermore, the literature reflects a growing consensus regarding appropriate goals and targets in preventive practice. Various writers take the position that valid goals for preventive practice are to promote developmental processes as well as to prevent the occurrence of disorders.[20] In addition, they propose that because primary prevention is concerned with populations that are free of the disorder at issue, services are properly targeted either to an entire population or to persons within a population who are thought to be at particular risk.[21] With this theoretical perspective in place, next steps will depend on social as well as professional commitments to prevention goals and will require the design and implementation of longitudinal studies.[22]

PRIMARY PREVENTION IN FAMILY AND CHILDREN'S SERVICES

While much of the writing on primary prevention has been concerned with mental health practice in the clinical sense, this paper was assigned the task of exploring the extent to which the concept is applicable to social services that address problems of family functioning and child development. The question is: can primary prevention, with its reliance on the examination of social conditions and appropriate environmental intervention, improve the social service design in family and childrens services?

The current direction in child welfare, as evidenced in PL 96-272, in the child welfare literature, and, to some extent, in practice, conceptualizes the needs and social service design for children in relation to their membership in families and their need for permanent, family attachments. Family focused practice is essentially an ecological focus, because both are concerned with facilitating the fit and enhancing the exchanges between persons and environments. In family practice, the family is viewed as the primary environment in which children grow, and services are designed to maximize the family's capacity to meet the development and maturational needs of all its members. However, the family is seen as interacting with and dependent on its social environment for the resources and supports that it needs to carry out the child rearing responsibilities in ways that enhance both the parents' adult functioning and the child's development.

Because of child welfare's long and intimate knowledge of the serious outcomes of family breakdown, the obligation "to try" to incorporate prevention in its intervention continuum is a compelling one. Ecosystems theory provides the theoretical link that connects environments and human development. This provides a framework that will allow the formulation of hypotheses to guide serious studies of what, if any, preventive strategies prove effective in improving parents' abilities to nurture their offspring to health and maturity and in reducing the incidence of bio-psycho-social dysfunctions that too often impact the lives of our children and youth.

To include and build both the goal and a method of primary prevention successfully in child welfare services would indeed make an important first step in transforming the system from its current residual place toward becoming a first line support system for the broad sweep of American families. Particular to the task of this paper, however, primary prevention has a unique conceptual

contribution to make to any serious effort that proposes to improve the accessibility and the cultural relevance of services for dependent children from minority group communities, particularly Black children who are seriously over-represented in the system.[23]

Family-focused services represent the second step in the revision of the child welfare system that this paper proposes. It is a focus that should help reverse unwarranted separation of many minority children from their families. Because the system has been protective in its orientation, there is no question that by the time services are activated, many families are in serious disarray and some are at high risk. However, without prevention, early problem-solving services and active rehabilitation services, it is not possible to support, to test, and – wherever possible – to facilitate the unfolding of a family's potential to function. Rather, it is the practice to intervene at the residual end of the service continuum either with minimal protective supervision of children in their own homes or, more likely, protection through placement and out-of-home care. And, too often the out-of-home placement is under conditions of marginal to poor care, discontinuity, and impermanence which constitute devastating environmental stress for the developing persona.

CONCEPTUALIZING PRIMARY PREVENTION SERVICES FOR MINORITY FAMILIES AND CHILDREN

Based on a literature review and analysis to determine an appropriate framework for studying Black families, Allen concluded that "while family functions are more or less universal, situational constraints vary and, therefore, dictate the adoption of culturally distinct styles of organization and interaction." With this, he provides us with an analytic principle that is generalizable to families in all of the society's racial minority populations due to the fact that they live in distinct socio/cultural environments that differ markedly from the environments of white families.[24] Minority families, each in its own way, relate to the norms, traditions, support systems, and circumstances of the ethnic community. At the same time, their lives are influenced and largely controlled by the social arrangements of the larger society. This perspective centers on the fact that racism is intrinsic to American society, and its effects – exclusion, economic disadvantage, restricted opportunity, and powerlessness – impact minority communities and family life.

A common complaint among the groups has been the overall failure of social services in minority communities to seek to understand minority communities or to invest helping resources in efforts to support and sustain minority families. Primary prevention, with a fundamental concern for contextual issues, is described by its theorists as an enabling intervention. It has promise for operationalizing child welfare's ubiquitous but imprecise notion of "strengthening family life" and for helping social services meet the expectations that racial minority communities have for them.

The state of the art in primary prevention includes a growing consensus with regard to the following points. The ecological/developmental perspective is emerging as a useful theoretical guide. A trend is developing toward agreement about appropriate targets and goals of prevention practice; and a number of studies and programs have been undertaken which report and document the feasibility of doing primary prevention.[25] The recommended next step is the development of an empirical data base. This paper proposes that conceptualizing primary prevention from the minority perspective will make an essential contribution to that process.

PREVENTIVE SOCIAL WORK PRACTICE IN FAMILY AND CHILDREN'S SERVICES: THE CURRENT SCENE

In her recent review of social work literature for the years 1975 through 1980, Caple found reports of 63 examples of agency-based, preventive, social work practice on the behalf of children. This practice took place in a variety of social agencies and related settings serving families or children; both in primary settings for social work/mental health services and in secondary or host settings, namely public schools, hospital in-patient services, medical clinic out-patient services, and a public health agency. Twenty-one prevention programs were reported by the combined health services; 16 by public schools; 14 by general family and children's service agencies, including child guidance clinics; five by adoption and foster care services; only two by public child protection services.[26] For our purpose, this sample establishes that preventive practice with families and children can be done, and many programs report that the intervention has made a difference. The Caple study suggests that although the exception, preventive practice has made inroads into family and child welfare services. Given the overrepresentation of Black and Hispanic children in that

system, notably the public services, it is essential that primary prevention is conceptualized and studied with the particular needs of those populations in mind.

INCORPORATING THE MINORITY PERSPECTIVE IN PREVENTIVE PRACTICE

In relating primary prevention to the perspective of people of color, the principle that prescribes that preventive strategies are appropriately, in fact necessarily, directed at stress producing environmental forces as well as to vulnerable or "at risk" populations is an important one. With that principle in mind, it is therefore axiomatic that the extent to which racism, exploitation, dysfunctional social institutions, and poverty and economic marginality dominate social arrangements, they will create and sustain the potential for families to fail. Minority group families are uniquely vulnerable to these forces. It is, therefore, important to confirm that the first strategies for safeguarding family life, the current political and fiscal conservation notwithstanding, must be guarantees of economic stability, occupational and income security, quality education, health services, and fair and equal access to these and other opportunity systems.

Such macro strategies for environmental change, then, would be well complemented by a social service system that is conceptualized and designed for family-oriented practice. The system's program goals would include the enhancement of family and child development, the prevention of bio-psycho-social disorders in parents and children as well as the maintenance of quality restorative, protective, and placement functions. The ethnic relevance of the service model, however, would require the incorporation of both the family perspective and the minority perspective in the theory building process for preventive practice.

The combined family/ethnic perspective calls for changes in the traditional uses of the theories of personal maturation and personality development. It implies the need for other assumptions about how growth tasks are resolved at the various crucial points along the developmental trajectory by taking account of how universal growth themes are influenced by family patterns and by the social realities that are particular to the several minority communities. In other words, we need a developmental paradigm that assumes that the transactions among child, family, and specific environmental forces (the eco-systems model) can do much to explain parental behaviors, family operations, and child/

adolescent development. This provides for assumptions from which hypotheses can be formulated as the beginning of empirical study of the effectiveness of various preventive strategies for reducing the prevalence of many circumstances that seriously threaten the quality of life for unconscionable numbers of minority group children.

The paradigm provides for a systematic approach to the study of such questions as: To what extent can primary prevention hinder the increasing incidence of one parent families?[27] To what extent can primary prevention prevent overwhelming stress for single parents and promote balance and functioning in one-parent families? To what extent can primary prevention foster bonding and growth producing parent/child relationships between mother and child in the growing number of families headed by adolescent mothers who keep their babies?[28] To what extent can primary prevention promote bonding and family formation in adoption?[29] To what extent can primary prevention improve the fit and the quality of exchange and learning between public schools and poor children? To what extent can primary prevention hinder what Glasgow has identified as a growing underclass into which Black adolescents, in increasing numbers, are being trapped?[30] To what extent can primary prevention enhance the sense of personal self-directedness that is so essential for group empowerment?[31] To what extent can primary prevention support minority children in the natural bend toward positive identification with one's own ethnic group and culture,[32] offering a consciously devised alternate to any ultimate need for ethnotherapy?[33]

These are but a few of the issues that lend themselves to systematic study of primary prevention and the potential of preventive practice for improving both the effectiveness and usefulness of family and children's services in the current social context. A special case has been made here for the need to design such services to be culturally sensitive and relevant for families and children of color who live as Americans with important and strategic ties to their ethnic communities and cultural traditions.

Conclusion

Issues of American traditions, values, and attitudes with regard to families, children, and racial minority populations have been raised here as a background for viewing the particular problems

involved in developing a design for contemporary family and children's services incorporating the concepts of ethnic-sensitive practice and primary prevention. Once again the case is being made for the need to have child welfare services begin the transition from being a residual system to becoming a primary resource for modern American families of all backgrounds. This paper takes the position that the prerequisite of such a transformation will require major reform of the national network of public child welfare services. Firm commitment, investment, and achievements toward uniform excellence in the public services are prerequisite to an effective coordination of public and voluntary services into a system that has every potential for developing an image of being at work on behalf of families and children and against environmental stress. The current conservative trend in the nation makes this old proposal even less congruent with social sentiment than it has been in times past. However, the need grows and will continue to grow as environmental stressors multiply daily, placing more and more families in danger of losing the struggle to cope.

Notes

1. Leon Chestang, "Environmental Influences on Social Functioning: The Black Experience," in *The Diverse Society: Implications for Social Policy*, ed. Pastora San Juan Cafferty and Leon Chestang. (Washington, D.C.: National Association of Social Workers, 1976), pp. 59-74.

2. John A. Calhoun, et al., *The Status of Children, Youth, and Families 1979* (Washington, D.C.: U.S. Department of Health and Human Services, DHHS Publication No. (OHDS) 80-30274, 1980), pp. 191-251.

3. Andrew Billingsley and Jeanne M. Giovannoni, *Children of the Storm: Black Children and American Child Welfare* (New York: Harcourt, Brace, Jovanovich, 1972), p. 3.

4. June Brown, "Adoption: Its Place and Purpose in a Contemporary Concept of Child Welfare Services," *Social Work Papers*, Vol. 15 (Fall 1979), p. 11.

5. For example see Mary Lee Dunu, "The Lower East Side Family Union Assuring Community Services for Minority Families," in *Home-Based Services for Children and Families: Policy, Practice and Research*, ed. Sheila Maybanks and Marvin Bryce (Springfield, Ill.: Charles C. Thomas, 1979), pp. 211-24.

6. Harriet Goldstein, "Providing Services to Children in Their Own Homes: An Approach that can Reduce Foster Placement," *Children Today*, Vol. 2 (July-August 1973), pp. 2-7; Josephine Hirsch, Jacquelynne Galley, and Eleanor Schmeri, "A Child Welfare Agency Program of Services to Children in Their Own Homes," *Child Welfare*, Vol. 55 (March 1976), pp. 193-204; Mary Ann Jones, et al., *A Second Chance for Families: Evaluation of a Program to Reduce Foster Care* (New York: Child Welfare League of America 1976); Maybanks and Bryce, eds. *op. cit.*, see Mary Ann Fahl and Donna Morrissey, "The Mendota Model: Home-Community Treatment," pp. 225-36; David Haapala and Jill Kinny, "Homebuilder's Approach to the Training of In-Home Therapists," pp. 248-59; Theodore Levine and Elizabeth McDaid, "Services to Children in Their Own Homes: A Family-Based Approach," pp. 260-74; and Douglas Stephens. "In-Home Family Support Services: An Ecological Systems Approach," pp. 283-96.

7. For example see Marilyn Elias, "Dependency Court: Children in a Web of Bureaucracy," *Los Angeles Times*, 7 April 1982, Part V., p. 1; "Farm School Turns

out to be a Rustic Slum," *Los Angeles Times*, 13 June 1982, Part I., p. 3; John R. Hurst and Ronald B. Taylor, "Cast off Children," *Los Angeles Times*, 13 June 1982, Part I., p. 1; and "Mary, A Victim of the System, Has Known 26 Homes," *Los Angeles Times*, 13 June 1982, Part I., p. 3.

8. Grace Abbott, *The Child and the State, Vol. I, Legal Status in the Family, Apprenticeship, and Child Labor* (Chicago: University of Chicago Press, 1938), pp. 259-69.

9. William T. Hagan, *American Indians* (Chicago: University of Chicago Press, 1961), pp. 121-50.

10. PL 96-272, *94 Stat.*, pp. 500-535.

11. *Ibid*, Sec. 425 (a) (1), p. 519.

12. *Ibid.*

13. *Ibid*, Sec. 471 (a) (15), p. 501.

14. June Brown, Wilbur Finch, Helen Northen, Samuel Taylor, and Marie Weil, *Child, Family, Neighborhood: A Master Plan for Social Service Delivery* (New York: Child Welfare League of America, 1982), p. 29.

15. *Webster's New World Dictionary of the American Language*, College edition (1966), "prevent."

16. Dale W. DeWild, "Toward a Clarification of Primary Prevention," *Community Mental Health Journal*, Vol. 16 (Winter 1981), p. 307.

17. Bernard L. Bloom, "Prevention of Mental Disorders: Recent Advances in Theory and Practice," *Community Mental Health Journal*, Vol. 15 (Fall 1979), pp. 179-91; Martin Bloom, "A Working Definition of Primary Prevention Related to Social Concerns," in *Primary Prevention in Mental Health and Social Work*, ed. Milton Nobel. (New York: Council on Social Work Education, 1981), pp. 5-12; DeWilde, *op. cit.*, pp. 306-316; and Ricardo F. Munoz, "The Primary Prevention of Psychological Problems," *Community Mental Health Review*, Vol. 1 (1976), pp. 4-15.

18. B. L. Bloom, *op. cit.*, p. 189.

19. Munoz, *op. cit.*, p. 8.

20. M. Bloom, *op. cit.*, p. 10; Carel B. Germain, "Teaching Primary Prevention in Social Work: An Ecological Perspective," *Journal of Education for Social Work*, Vol. 18 (Winter 1982), p. 21; and Munoz, *op. cit.*, p. 8.

21. M. Bloom, *op. cit.*, p. 10; and Munoz, *op. cit.*, p. 10.

22. Munoz, *op. cit.*, p. 10; and B. L. Bloom, *op. cit.*, p. 189.

23. Ann W. Shyne and Anita G. Schroeder, *National Study of Social Services to Children and Their Families*, (Washington, D.C.: DHEW Publication (OHD) 78-30150, 1978), p. 30. This study reports that among the 1,800,000 children who, by statistical estimate, were served by public social services in the first quarter of 1977, a higher proportion of Black than of white or Hispanic children received services. The ratios of children served to the population were as follows: White 20/1,000; Black 51/1,000; Hispanic 25/1,000.

24. Walter B. Allen, "The Search for Applicable Theories of Black Family Life," *Journal of Marriage and the Family*, Vol. 40 (February 1978), pp. 125-26.

25. Frances Smalls Caple, "Preventive Social Work Practice: A Generic Model for Direct Service on Behalf of Children," (Ph.D. diss. University of Southern California, 1982).

26. *Ibid.* p. 69.

27. Harriet P. McAdoo, "Demographic Trends for People of Color," *Social Work*, Vol. 27 (January 1982), p. 18.

28. *Ibid.* p. 21.

29. Joan Ferry DiGuilio, "The 'Search': Providing Continued Service for Adoptive Parents," *Child Welfare*, Vol. 58 (July-August 1979), pp. 460-65.

30. Douglas G. Glasgow, *The Black Underclass: Unemployment and Entrapment of Ghetto Youth*, (San Francisco: Jossey-Bass, 1980), pp. 1-15.

31. Shirley F. Berman, and Annette U. Rickel, "Assertive Training for Low-Income Black Parents," *Clinical Social Work Journal*, Vol. 7 (Summer 1979), pp. 123-32; and Barbara Bryant Solomon, *Black Empowerment: Social Work in Oppressed Communities*, (New York: Columbia University Press, 1976), pp. 21-22.

32. Madison Foster and Lorraine R. Perry, "Self-Valuation Among Blacks," *Social Work*, Vol. 27 (January 1982), pp. 60-66.

33. Price Cobbs, "Ethnotherapy in Groups," in *New Perspectives on Encounter Groups*, ed. Lawrence Salomon and Betty Berzon. (San Francisco: Jossey-Bass Inc., 1972), pp. 383-403.

4

Preventive Programming in Health and Mental Health For Ethnic Minorities

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Two recently published volumes have graphically and significantly contributed to our understanding of the state of the art of prevention in the area of mental health. The first, *Prevention in Mental Health: Research, Policy and Practice*,[1] reaches beyond the traditional concern with the psychological well-being of individuals to identify the mediating role of selected, but critical environmental variables: families, neighborhoods, churches, self-help groups, and voluntary associations. The potential for preventive intervention is highlighted, particularly within the context of the current programmatic philosophy – community mental health. Utilizing as examples such problems as domestic violence, divorce, child abuse and neglect, and such settings as schools, industry settings, and social networks, the authors cogently illustrate the current status of research, policy, and practice in the area of prevention. Our perspective is enhanced by some new notions on the

complexities and challenges to state and federal involvement in prevention, strategies and skills for promoting the public's health, and guidelines for evaluation.

The second volume, *Prevention: A Possible Science*[2] acknowledges, on the one hand, the recent developments in theory, practice, and research that permit the prevention of some social problems and the promotion of some social goals. Current gaps that limit the achievement of other critical social tasks are also identified. Proceeding with unabashed yet cautious optimism, the author outlines an orderly and systematic approach to dealing with a range of social problems and concerns. In the process, he challenges social work, among other professions, to assume responsibility for promoting a desirable future on behalf of individuals and groups for whom it historically has assumed responsibility.

The authors, writing in both volumes, individually and collectively, represent participants in a scenario which has been extant for centuries, namely extending the concern of practitioners from rehabilitation and curative care to prevention. Their contributions are critical to the objectives of this monograph in two respects. On the one hand neither volume focuses exclusively or intensively on the issue of promoting health, welfare, and quality of life of ethnic minority individuals or communities. Many of the problems considered, projects and research efforts identified, and theories posited are of import to ethnic minority persons and may well aid practitioners who work with such individuals. However, the ethnic specific applications of this preventive model, the gains which may ensue from this approach, and the techniques which would preserve the culture of minority groups without doing violence to their inherent values and positive behavior traits are yet to be identified and elaborated. That is the task of this monograph in general, and, with respect to health and mental health, the task of this chapter.

In the second case, by emphasizing the potential for preventing social and emotional problems the authors highlight the differentials in the development of preventive theory and programs between the areas of physical health and that of mental health. In so doing they again join forces, albeit not deliberately, in the long existing struggle to achieve greater coordination between health and mental health. A brief history of the process in developing preventive programs and knowledge in both areas, provide a backdrop for the discussion to follow.

Prevention in Health

Knowledge and skill during the earliest days of scientific medicine were, understandably rudimentary. Practice was based on the existing explanation of illness, initially seen as a result of disequilibrium between the four body humors: blood, phlegm, yellow bile, and black bile. Practitioners were influenced by an enormous respect for both nature and the human body, limiting their motivations to tamper with an acknowledged fine specimen. Consequently, the major interest and efforts were expanded in organizing medical practice and developing medical ethics. Despite this, an early thrust toward "health promotion" could be observed in the writings of Hippocrates and Aristotle, and particularly in their efforts to share their developing knowledge and views on health issues with the general public.

As early as 100 B.C. clearer evidence of systematic efforts at prevention were noted in the medical practices within the Roman Empire. In addition to developing hospitals to which citizens in almost every city could appear for medical and custodial care, the Romans made singular contributions in what we now know as public health. Public sanitation, in the forms of public and private baths, sewers and aqueducts, and obligatory street cleaning undoubtedly protected healthy citizens from contracting known and unknown diseases. Similarly, the initiation of free public health education and the appointment of regional physicians to care for the poor no doubt contributed to preventing the spread of disease, resulted in early diagnoses and care, and had a positive effect on the general health of citizens.[3]

During the middle ages, medicine, among other sciences, was subjugated to religious dogmatism. Known practices and knowledge resulting from earlier scientific observation and experimentation were abandoned or substituted with practices having their origin in religious faith, folklore, and teachings of the church. Previously developed public sanitation measures were allowed to disintegrate, with concomitant effects on the health of the public. In view of these events, disease – which was interpreted on religious grounds as natural phenomenon or the just rewards for a life of sin – was widespread, and in large cities, exacerbated by crowded living conditions. Historical literature is replete with reports on the facile spread of highly contagious diseases and epidemics, the most notable being the bubonic plague which almost depleted the existing population. While the motive may

have been one of "self-preservation" the use of quarantine as a preventive measure was among the various efforts to cope with the serious and devastating spread of illness and disease.

Following the Medieval Period, which was characterized by little or no medical advances, the Renaissance Period and the 17th Century were, in marked contrast, periods of enormous growth and development in scientific approaches to medical care. Progress was achieved in diverse areas, including the discoveries of body organs, the identification and classification of diseases, the invention of medical tools and instruments and the organization of practice. The invention of as crucial an instrument as the microscope and the establishment of medical journals permitting the exchange of information regarding new developments among professionals, and ostensibly the general public, constituted, in large measure, a preventive potential on which practitioners failed to capitalize. Coe notes:

> The seventeenth century might be characterized as the period of contrast in medicine. There was the invention of tools and equipment, but their application was largely overlooked: new data collected and analyzed by scientific methods were added to medical knowledge but lacked an outlet in medical practice, and finally there were advances in clinical medicine, but no organization or classification of these improvements . . . . . Unfortunately, identification of various symptoms progressed more rapidly than the organization of these data into a usable classificatory system. As a result, practicing physicians, unable to apply their new knowledge, continued to practice medicine based on ancient teachings.[4]

Two significant developments in the 18th and 19th centuries – the discovery of several bacilli (cholera, tuberculosis, anthrax, etc.) and vaccines (smallpox) and the invention of several useful medical instruments (stethoscope, ophthalmoscope, larygnoscope) – laid the groundwork for the formulation of the germ theory of disease. The prevailing philosophy in medical practice was that each disease had a specific pathogenic course, giving impetus to the removal or control of the specific causal agent as the main objective of medical practice. Public health in its modern form emerged as a result, since with the identification of the causes of numerous infectious and communicable diseases, it wasn't long until practitioners discovered that sanitation services and innoculation prevented the spread of such diseases.

The currently familiar trichotomy of primary, secondary, and

tertiary prevention did not emerge immediately. When first conceptualized by Johan Frank, primary prevention had as its sole concern the large scale control of communicable disease, by interrupting their transmission initially through sanitation.[5] With the advent of bacteriology the scientific prevention of certain infectious diseases through immunization was seen as another way to achieve this objective. Seemingly more for theoretical consistency than for scientific accuracy, two forms of curative care have since then been labeled as prevention: namely the treatment to halt the progress of diseases and their side effects as secondary prevention; and efforts to restore individuals effected by the disease to the highest level of functioning as tertiary prevention. Much has been written about the confusing implications of extending the label of prevention beyond "primary prevention" and this discussion will not replicate those concerns.

Twentieth century medicine has been characterized by both the consolidation of previously developed knowledge and skill and by a remarkable acceleration of new developments along several fronts – knowledge, technology, and ethics. Simultaneously, the central concern of medical practice has shifted from communicable diseases to chronic diseases – heart disease, cancer, and arthritis, for example – where medical knowledge of causes is still incomplete. Consequently, the model of prevention that emphasizes the strategy of interrupting the chain of transmission has lost its relevance, inasmuch as chronic diseases tend to be a result of multiple causes and because they are not communicable, as in the case of infectious diseases.

Prevention in Mental Health

The chronological elaboration of the development of preventive practices in the field of mental health is admittedly brief for several reasons, primary of which is the fact that only recently have practitioners and theorists begun to see this as possible, and secondly because at no time has mental illness been seen as having a specific, organic etiology (except in the cases of illness resulting from syphillis of the brain, genetically induced schizophrenia, and the organic brain syndromes). Consequently mental illness does not lend itself to the model of prevention developed in physical medicine, although there have been efforts to equate the two and to transfer concepts and practices from the former.

Nevertheless, some efforts at preventing mental illness in the past are worth noting, if for no other reason than to put things in perspective. Prior to the Middle Ages, mental illness was conceptualized in supernatural or demonological terms. Individuals, labelled as distracted, possessed by demons, or touched, were initially left as the sole responsibility of their relatives (who tended to hide them away from the general public) and later, as they increased in numbers, were lodged in almhouses with the poor, lame, blind, and other dependent persons. Remedies for dealing with the illness included blood letting, and shock restraints. Prevention was inconceivable to practitioners mainly because of a sense of impotence in relationship to the conceived causes.

During the Middle Ages, mental diseases continued to be considered in supernatural terms. However, because of the prevailing philosophy, persons exhibiting such bizarre or unorthodox behavior were dealt with swiftly and harshly. Persecution and death were the most typical responses to these individuals. In this social climate, characterized by extreme orthodoxy, prevention if any thought was given to the concept, was predicated on individuals repenting their lives of sin and establishing a firm, undying commitment to God. Practitioners, or, in reality, custodians did not consider themselves as having either the responsibility or opportunity to influence the will of God.

The task of Renaissance and post-Renaissance practitioners was to combat the notions regarding supernatural forces as causal to mental illness and to develop explanations of disease and concomitant practices which would be compatible with the developing knowledge. The study of anatomy that provided considerable impetus to advances in clinical medicine was not as successful in providing the evidence of pathological, organic processes to explain abnormal behavior.[6] Despite this, efforts originating during this period culminated in widespread public acceptance of physicians and medicine as legitimately responsible for the care, cure, and if possible, the prevention of mental illness.

During the 19th Century, advances in mental health were as dramatic as those in clinical medicine, albeit of a different nature. After centuries of competing and confusing approaches, to the care of the mentally ill, the precedent-setting perspective known as Moral Treatment was developed and applied.[7] While this approach did not enjoy a long existence, and while it benefited only a small portion of those affected by disease, this school of psychological medicine was important for a number of reasons. It was the first

approach to the care of the mentally ill that was systematically articulated. It also was almost uniformly supported and utilized by the major and most influential leaders of the profession. Development of this approach had implications for prevention in two significant ways.

First, it should be remembered that public health originated during this period with enormous success in controlling the environment through sanitation, and as a result limiting the transmission of disease. Physicians concerned with the attenuation and prevention of mental illness were influenced by these developments and focused on sanitizing the physical and social environment. Their efforts involved lobbying for sanitary and labor codes, crusading for various reforms, suggesting the limitation and availability of noxious substances (e.g., prohibition) and other supposed causes of mental disturbance (e.g., religious mania) and in general, seeking to improve the life of the insane.[8]

Secondly, most of those in support of this approach assumed or were assigned responsibility as superintendents of psychiatric hospitals, and constituted themselves as founding fathers of the Association of Medical Superintendents. As part of their professional responsibility they engaged in broad based efforts of mental health education, an accepted preventive strategy.[9] Among other things they:

1. Published exclusively in the *American Journal of Insanity*, whose stated purpose was to popularize the study of insanity, to acquaint the general reader with the nature and varieties of the disease, methods of prevention, and cure.
2. Defined populations at special risk, especially children. (Although given our current knowledge and perspectives, we may raise questions regarding the populations identified – those with dark hair, those rich and idle who, unlike the toiling, pragmatic poor, had leisure to look back upon past and to anticipate future and imaginary evils. This was a forward-looking approach.)
3. Offered a range of suggestions designed to educate parents on appropriate child care and child rearing practices, and related suggestions to safe adult health.
4. Informed the public against hazards in the physical and social environments (albeit some items which might pro-

voke current laughter such as popular novels and Gothic tales).

5. Oriented their practices and publications to the problems of large populations, and not solely to the individual patients of concern.

Of particular import to the concerns of this monograph, it should be noted that moral treatment was predicated on the cultural similarity between practitioners and their patients. Indeed the ultimate demise of this approach and the return to custodial care were precipitated in part by the increasing conviction of the alienists or practitioners that their system was not universally applicable and/or suitable for immigrants and the culturally different – Irish and German peasants, and no doubt the Negroes who migrated from the South and whose insanity rates had surged to 1 in 44 in Massachusetts and 1 in 14 in Maine, as compared to 1 to 4,310 in Louisiana and 1 to 1,309 in Virginia.[10]

As in the case of clinical medicine or physical health, the twentieth century has been a period of consolidation and simultaneous knowledge explosion in the field of mental health. Energies have resulted in remarkable success in defining mental illness and mental health, developing conceptual and practice models for treating mental illness, implementing epidemiological and related research, and recognizing the import of the social process of hospitalization. In the 1900s developments including the increasing utilization of crisis intervention, developing the philosophy of the therapeutic community and the discovery, and widespread use of psychotropic drugs converged to radically change the approach to the care of the mentally ill. The success in reducing the anxiety, discomfort, and bizarre behavior of psychiatric patients enabled practitioners and administrators to discharge large numbers of patients who had been hospitalized for decades and to care for others, who might have been previously doomed to similar fates, in their homes and communities. These and other factors constitute important precedents to the development of community mental health, some of whose salient characteristics are its emphasis on preventive services, as distinguished from therapeutic services; its emphasis on a total community or population, rather than individual patients; and its emphasis on continuity and comprehensiveness of services, challenging programs to meet the full spectrum of mental and health related needs of the respective communities.

The Mind-Body Conflict

The conscious distinction between physical and mental health requires a brief discussion before proceeding with consideration of other issues. The distinction is not a simple academic one, for as Coe noted,

> while medicine has become scientific in the modern sense of the word, it has never really lost the social insights of previous generations. However, for the first time conscious distinction has been made between the "science" and the "art" of medicine and, except within modern psychiatry, formal instruction and academic interest alike have centered almost wholly on science. Because medical science has been defined almost entirely in biological terms, this distinction has pushed interest in the social aspects of medicine to the periphery of medical consciousness. With the development of the germ theory of disease and the concurrent progress in physiological medicine, the "medicine of the internal environment," it seemed that the theory of pathology had been reduced to the analysis of the response of the organism to deleterious physical and chemical stimuli. The tremendous successes in the management of disease which this theory won reinforced the tendency to think of medicine as exclusively a biological science, even its social organization was conceived as ideally determined by criteria of efficiency in implementing technical, diagnostic, therapeutic and preventive operations.[11]

The forces promoting specialization and continued distinction between health and mental health issues are numerous and intransigent. The rewards of such specialization – including the speed and ease of generating specialized knowledge, the tangible and intangible benefits immediately available to specialists, and the politics on state and national levels that encourage legislators to develop and maintain categorical programs – all inveigh against conscious and systematic efforts to develop a system of coordinated care. Similarly, the forces remain operative even in light of clearly recognized facts that most disease processes include both physiological and psychological reactions on the part of patients afflicted. What is even more critical is that initial specialization(s) in interest and knowledge tend to reinforce specialization in application of that knowledge – treatment. When dependent solely on the interest, training, and skills of the provider, the application of such knowledge often operates to the detriment of the patient whose physical health or mental health needs may be overlooked

in the process of coping with a single symptom or isolating a single problem.

Lest we become too discouraged immediately, it is important to note that various counteracting forces exist that seek to promote closer coordination of health and mental health care. These forces, structural, intellectual, financial, and political in nature, are inextricably tied to each other. This is remarkably evident in the Community Mental Health Centers Act and its regulations and subsequent amendments which revolutionized the care of the mentally ill. There is no question but that a plural number of explicit and implicit objectives gave birth to this landmark social policy. But, as Bloom notes,

> Not far beneath the surface of the Community Mental Health Centers Act, then, may be a view of a single integrated and comprehensive community-based health-delivery system attending equally to biological and psychological problems of the individual.[12]

More recent federal policies have contributed to the increasing coordination of care, including the recommendations made by the President's Commission on Mental Health and the Mental Health Systems Act of 1980, sponsored to implement the major proposals of the Report.

As recent as November 25, 1980, national health planning goals developed by the Department of Health and Human Services, and published in the *Federal Register*, called for locating mental health professionals in primary care programs, recommended in-service mental health training for primary care providers, and called for organizing mental health, drug abuse, and alcoholism services that would improve the coordination with the mainstream of health care. The increasing appreciation and utilization of multidisciplinary teams, integrated clinical records, consultation, joint intake, assessment and triage functions, and case management services all augur well for increased active and productive collaboration between health and mental health professionals, as do joint training programs, research activities, and the sharing of physical concern for patients who do not themselves specialize in their needs or requests.[13]

Preventive Programming in Health and Mental Health for Ethnic Minorities

While the Community Mental Health Act and ideology crystallizes the efforts of the federal government to unite mental health with general health services, critical to the interests of this monograph is that the Act simultaneously provides an organizing framework for developing and implementing preventive services. Much has been accomplished in this arena, but the special relevance of prevention to ethnic minority individuals and communities, and of preventive services as a unit of practice has not been articulated or highlighted. This serious gap is explained, in part, by the difficulties in operationalizing prevention into useful practice principles. It is further explained, more pertinently, by the apparent assumptions of theorists and practitioners that the general theories and models of prevention will serve all people equally, and, if anything, preventive practices should be color blind. The result, regardless of the rationale, is a marked deficit in the development of knowledge and skills which systematically address the promotion of health, the prevention of problems or diseases specific to ethnic minorities (a good example being sickle cell anemia), and the quality of life of large numbers of minority persons.

The following discussion is a beginning attempt to organize some of the knowledge applicable to preventing health and mental health problems in ethnic minority communities. It is divided into four sections: (1) The Preventive Perspective defines prevention and provides a viewpoint of its specific relevance to ethnic minorities; (2) The Preventive Imperative reviews the breadth and range of physical and mental health problems affecting minority persons and suggests how important it is to work at preventing these problems in ethnic minority communities; (3) The Preventive Potential highlights some of the current resources in ethnic minority communities on which preventive programming can be erected; and (4) The Preventive Practice suggests a few of the practices that would attend to the problems confronting minority communities and individuals.

The Preventive Perspective

Published literature related to health and mental health prevention reveals that professionals do not agree on the definition of

"prevention" nor on the strategies and approaches associated with implementation of preventive technologies. In Emory Cowen's words, prevention is "a deliciously attractive but very slippery concept." [14] The significance of the term was articulated by the Task Panel on Prevention, in a report submitted to the President's Commission on Mental Health. In the Panel's words, prevention is the "fourth revolution . . . whose time has come."[15]

While some authors spend considerable time in distinguishing differences between and among levels of prevention – primary, secondary, and tertiary – and establishing objectives and strategies associated with prevention, others question the use of the generic term, *prevention*. When they do, however, reserve their emphasis solely to primary prevention (as is attempted in this discussion) they all seem to agree that *prevention* involves professional actions to forestall the generation of undesirable consequences.

To avoid the development of mental or physical problems or diseases, three approaches are postulated in an Alcohol, Drug Abuse, Mental Health Administration (ADAMHA) *Prevention Policy Paper*, namely:

> Health Promotion embodies an approach to fostering positive behaviors and general good health practices primarily through public education and information dissemination. Health promotion activities are designed to 1) encourage individual behavior change and 2) improve socioeconomic and physical environments.
>
> Health Protection embodies an approach to fostering general health through direct public regulatory and control activities, particularly those related to environmental factors affecting health (e.g. water purification and chlorination).
>
> Disease Prevention encompasses services to prevent the occurrence of specific disorders, using strategies derived from analysis of risk factors of such disorders.[16]

Certain implications of these approaches, particular to the interests of ethnic minority communities are made explicit.

First, the approaches conceptualize the beneficiaries of preventive programming along a continuum, somewhat in contrast to other definitions. It considers as legitimate and useful projects and activities that influence the lives of individuals and equally beneficial those programs with potential benefits for large numbers, or in this case whole ethnic minority groups. The perspective in direct practice which encourages social workers to make public issues of private troubles is a well accepted viewpoint. Devore and

Schlesinger, in their model of direct practice with ethnic minorities, make a compelling plea for a perspective which encourages simultaneous attention to micro and macro issues, noting that:

> The social worker must look beyond the problems presented by individual clients to see if there are others suffering from the same problem. The perspective also serves to call attention to those community and ethnic networks in which people are enmeshed and which can be called upon to aid in the problem resolution. Problems as identified by the client or social worker, have diverse sources and call for a variety of systemic and individual actions. . . . Social workers must be attuned to both levels of intervention as they go about the task of helping people who are caught in the clash between varying cultures.[17]

The integration of multifacted preventive objectives (those affecting individuals, the community of minority groups, and the larger social system in which they operate) must be a basic component of any model of prevention if the latter is to be relevant and sensitive to the groups involved. Many undesirable consequences are generated at the interface between ethnic minority individuals and their environments. Similarly, many of the problems desirably preventable involve economic and social inequity and their concomitant consequences for individuals and the larger group. Consequently, an ethnic sensitive model of prevention must call attention to the consequences of racism, poverty, and discrimination to individuals and the collective, and thus requires simultaneous attention to micro and macro tasks, objectives, and results.

Secondly, the approaches in suggesting the desired use of strategies derived from an analysis of risk factors speak to the development of interventive techniques which take into consideration the ethnic reality. For example, data presented by the United States Department of Health, Education and Welfare in 1978 indicated that among urban Blacks, immunization for measles, rubella, polio, mumps, and diphtheria-tetanus-pertussis were least likely among the poor in central cities. A related broad based study in Watts, California, resulted in findings that revealed that immunization may be related to age; that immunization, preventive medicine, and annual examinations appeared to be unaffordable luxuries for poor Blacks who may be willing to consider preventive care subsequent to the solution of acute environmental problems.[18] In view of these data a preventive practitioner seeking to promote the

health, improve the quality of life and preclude obviously preventable diseases among ethnic minority groups would have to consider such factors as transportation, socio-economic status, and location of the clinics, which increases the acceptability and utilization of immunization programs. Vaccines and immunization clinics may be necessary, but obviously are not sufficient conditions in preventing disease among minority groups.

In the third place, these approaches suggest that diseases and other undesirable states have multiple causes and that precise and specific etiologies are frequently unidentifiable. Practioners, seeking to serve ethnic minority populations with identified problems through direct service have repeatedly been overwhelmed with the intransigence and multifaceted nature of their problems. Similarly, preventive practitioners would be advised to consider the search for associated and/or precipitating factors as more viable and useful, rather than causal and predisposing factors to problems faced by these groups. This view is firmly supported by the systems concept of "equifinality" which suggests that a variety of stress producing or precipitating events may result in or be associated with the development of a range of disorders or negative outcomes. This perspective also decreases the stigma frequently associated with the view of ethnic minority groups as "high risk populations" and encourages the attention given to "high risk situations".[19] As Bloom observes,

> four vulnerable people can face a stressful life event – perhaps a collapse of their marriage, or the loss of their job. One person may become severely depressed; the second may be involved in an automobile accident; the third may head down the road to alcoholism; the fourth may develop a psychotic thought disorder or coronary artery disease.[20]

Fourthly, implicit in these approaches is the assumption that minority individuals and communities have inherent health and potential(s) worth protecting from which positive health can be promoted. The strengths, coping or survival techniques, indigenous resources, and support systems of ethnic minority individuals and communities have only recently been identified. Minority theorists have similarly provided a more adoptive psychology than was previously attributed to ethnic minority individuals and groups. For example, Solomon observed that:

> Some negative valuations do not result in powerlessness because strong family relationships or strong, cohesive

> group relationships provide a cushion or protective barrier against the negative valuations from the larger society. Despite these negative valuations, some blacks, for example are able to obtain and utilize a broad range of personal, interpersonal and technical resources to achieve goals effectively. Not all blacks are powerless. This fact places into focus the goal of empowerment[21]

as a logical preventive objective for ethnic minority individuals, groups and communities. More will be said later about the preventive potential implicit in these indigenous resources of minority communities.

The Preventive Imperative

In keeping with the definition stated above, the major objective of prevention is to avert the development of a mentally or physically pathological state. Ultimately, practitioners seek to reduce the number of people who bear the brunt of undue stress, to reduce stress and stressors where they can be eliminated, and to reduce the risks of collections of individuals succumbing to stress. The activities designed to accomplish these objectives are multifaceted, are carried out in a range of settings or fields of practice and require the combined and prolonged contributions of social workers, professionals in physical medicine and mental health, and society at large.

While in general true, primary prevention activities especially geared to ethnic minorities are justified by the growing sense of dissatisfaction with the widening gap between their demonstrated need for help and the markedly unavailable and/or inaccessible human resources to meet those needs. Epidemiological data, particularly data on mortality and morbidity, reveal that those individuals who are members of racial and minority groups have been consistently and disproportionately represented among those most seriously affected. Given this fact, it would seem logical in a caring society that the prevention of these undesirable states would assume priority and higher allotment of resources.

For example, among Blacks and whites, both males and females, the four leading causes of death are diseases of the heart, malignant neoplasms, cerebrovascular diseases, and accidents. It should be noted, however, that the National High Blood Pressure Education Program does not advocate racially differentiated pre-

ventive and treatment measures. Yet, recent findings in a heart study among Black and white children, indicate that there may be differences in metabolic backgrounds for hypertension. The next highest cause of death for Black and white males and white females is suicide. Further analysis of the findings reveal a curvilenear relationship between age and suicide for white females, a linear one for white males and a weak relationship between the two variables for Black males.[22] The data further indicate that there exists different peak periods of emotional crises during the life cycle for each of the groups, which suggest some preventive potential. The fact that homicide is the fifth highest cause of death for Black males also suggests that greater attention be given to environmental differences as the source of Black-white variations in suicide patterns in the United States. As Hendlin states:

> With both black homicide and black suicide, one is dealing basically with a problem of the ghetto, i.e. with the poorest socioeconomic group among the black population . . . A sense of despair, a feeling that life will never be satisfying confronts many blacks at a far younger age than it does most whites. For most discontented white people the young adult years contain the hope of a change for the better. The rise in white suicide after 45 reflects, among other things, the waning of such hope that is bound to accompany age. Those blacks in the ghetto who survive past their more dangerous years between 20 and 35 have made some accommodation with life – a compromise that has usually had to include a scaling down of their aspirations.[23]

Similar conclusions can be drawn from data regarding other minority groups. For example, the most recent data systematically available revealed that the chief causes of death among Puerto Ricans under age 45 were accidents, homicide, and drug dependence. Accounting for 39 percent of all deaths in this age group, these rates were, in almost every case, nearly twice the rates for the general population. Harwood, noting that continuation of such a pattern would undoubtedly overextend the demands on public medical sources for treatment, suggests:

> Rather than waiting to treat these afflictions medically, it would seem both efficient and humane for health professionals as citizens, to begin exerting political pressure to remedy the causes of these problems through social, legal, economic and educational measures.[24]

No doubt he is alerting us to the preventive potential and imperative in this situation.

In the case of Mexican Americans, they, like their Anglo counterparts, die most commonly from heart disease and cancer though the rates are not quite as high. However, related studies indicate that Mexican Americans die more frequently than whites from cirrhosis of the liver, tuberculosis, diabetes, infectious and parasitic diseases, and accidents. Every one of these latter causes is currently preventable given our current knowledge and skills, but without the will they continue to plague Mexican American citizens.[25]

In the area of mental health of minority individuals, a similar pattern is noted. For example, a study of mental hospital admissions throughout the country indicates that during 1972 nearly three in ten Spanish speaking/surnamed Americans and nearly four in ten nonwhites admitted to state and county mental hospitals were given a primary diagnosis of schizophrenia. Alcohol disorders accounted for 15 percent and drug disorders for 17 percent of Spanish speaking/surnamed admissions and for 23 percent and 6 percent of the nonwhite admissions respectively. The same study revealed a wide and significant variation in the legal status of admissions to state and county mental hospitals according to ethnicity. Among whites over half of all admissions (52 percent) were voluntary, the most desirable form of admission to a mental hospital, if one has to be admitted. On the contrary, voluntary admission accounted for 43 percent among the Spanish speaking/surnamed group and 35 percent of the nonwhites admitted.

While the length of in-patient stay decreased significantly for all patients between 1964 and 1973, the overall length of stay was still greater for members of racial and other minority groups. Admission rates to these hospitals for minority patients were twice as great as for whites, and Blacks exceeded whites in mental hospitals by 52 percent. The study concluded that while racial minorities used more mental health facilities at greater rates than whites, they made greatest use of in-patient and publically funded facilities as compared to outpatient and private facilities.

Recently, the members of the Special Populations Sub-panels on Mental Health Issues of the four ethnic minority groups detailed for the President's Commission on Mental Health the pressing and overwhelming needs of their particular ethnic group.[26] Their documentation is so vivid that the reader is encouraged to review them in their original details. The most impressive aspect of

these data is the overwhelming repetition of negative indicators leading to the unmistakable conclusion that members of these groups are at enormous risk, concerning all aspects of mental health. Briefly, the following evidence was highlighted, indicating that ethnic minority individuals, families and communities:

1. suffer the full impact of a culture of poverty to a much higher extent than the general population;
2. have an increased prevalence of substance abuse, alcoholism and juvenile delinquency;
3. have a higher number of families devastated by mental illness and alcoholism;
4. experience high unemployment leading to mental illness, family disruption and alcoholism;
5. have less services available;
6. have an increased rate of institutionalization compared to a decreasing rate for whites, and simultaneously have low "treatment" rates;
7. are admitted, committed, or sentenced for custodial care sooner than whites;
8. are more disturbed than Caucasian patients on admission;
9. have a higher proportion diagnosed as psychotic;
10. receive less accurate diagnosis;
11. receive more nonspecific dispositions; and
12. are more likely to be seen for diagnostic purposes and less likely to be selected for insight oriented therapy.[27]

Beyond the higher rates than their white counterparts, careful and systematic analysis of these data repeatedly confirm the importance and impact of environmental conditions associated with but not inherent in the disease or disorder. The implications for prevention are obvious and compelling. Similarly, one cannot ignore the negative effects of these disorders on the health and social life of minority communities. Suicide, mental illness, drug addiction, and infectious and parasitic diseases all are major sources of stress to residents and families. The psychological toll of parents and relatives who wonder about the possibility of themselves or other significant family members being affected is considerable and the plight of those who suffer untold financial strain further compounds the issue.

The Preventive Potential

Although theorists differ considerably on the definition of prevention and on many of the major dimensions which characterize this construct, they appear to agree that preventive intervention is directed at persons in whom there is no identified disease or disorder. In effect, the potential beneficiaries are healthy (irrespective of how that construct is defined) and, even more critical, inherently possess the potential for positive growth and development. Indeed, Bloom, who observed that prevention has a clear obviating thrust, namely forestalling something untoward from coming into existence, highlights the corresponding concern with promoting desired goals. He ascribes considerable importance to actions designed to increase the incidence of a desired state of affairs in a specific population of persons with "potential" and "the promotion of positive events — personal competence and environmental supports."[28]

This assumption logically provokes the question: What factors exist in ethnic minority individuals, groups, or communities that constitute health and on which preventive intervention can be developed? This question is critical, inasmuch as many practitioners tend automatically to assume broad scale maladjustment and limited growth potential when confronted with ethnic minority individuals or groups. In another published document, I noted that until recently it was possible to predict with considerable certainty the responses of most ethnic minority clients to the racist and discriminatory practices that confront them daily.[29] However, the movements within each of the minority communities, beginning in the last 1960s have given rise to different behavioral expectations, expressions, and impetus to a more adaptive psychology and approach to role relationships. Self-esteem and a sense of worth, combined with a greater respect and appreciation for one's identity and the capacity to influence their lives are concomitant results for many residents of these communities. Action oriented efforts to correct past injustices, establish alliances with members of one's own group and with other minority groups, and directly confront the larger society with strident demands for equality, characteristic of the behavior of many members within these groups, have also resulted in a sense of achievement and empowerment. Appreciation of these changes and the implications for personal growth and development require a keen sense of differential diagnosis, new terminology and a new

perspective of cause and effect. Describing this process as observed in the Black community, Pinderhughes states it as follows:

> For many Blacks, the Black Power Movement meant learning and testing new roles; learning not to capitulate and surrender themselves; and experiencing a period of dictating, setting the structure and running the show in the important areas of their lives. For most Blacks it involved a new relationship to their own emotions, especially to anger toward Whites which they could not permit, accept and learn to master.[30]

Some of the outgrowth of the liberation movements and related developments have laid a solid foundation on which to develop preventive programs and projects, which ultimately empower ethnic minority communities. They, combined with the fact that ethnic minority individuals and communities are currently prepared to move beyond a survival stance, and a sense that they and their progeny deserve more opportunities and resources from relevant help-meeting institutions and with greater parity with majority groups constitute a sound potential for preventing programming. Suggested below are only a small number of the existing ethnic specific resources which, in tandem, constitute that potential.

1. Kinship and related bonds between ethnic minority group members that permit flexibility in performing family and other useful roles. Those bonds also permit group members to act in concert, to provide mutual supports, to meet mutual needs and to develop and organize resources and power.
2. Demonstrated capacity and willingness to generate educational, economic and political power needed to advance group movement.
3. Ethnic specific institutions, particularly the church, but also including schools, businesses, and other institutions.
4. Long standing orientations to achievement, work, and religious values.
5. Cumulative experience in taking initiative and exercising options regarding developments and problem solving in their respective communities.
6. Ethnic sensitive and relevant criteria for judging personal and group worth, and greater pride in their ethnicity and recognition of unique worth of their ethnic values, limitations, and pitfalls.

7. Responsiveness and purposeful interactions between their respective communities and the power structur which affects and influences their existence.

The Preventive Practice

Prevention, because of its complex objectives and the nature of the current social, emotional, and physical problems that confront minority people and that require intervention geared at preventing them, is not the sole responsibility of social work. Yet, because of its commitment, values, knowledge, and skills this profession has a unique contribution to make to achieve preventive goals. Collaborating with other professionals and stimulating society to assume a preventive stance will demand utilization of such skills associated with team work, client advocacy, lobbying, and social change. Most of the problems confronting ethnic minority individuals already require the application of these skills. When a preventive orientation is adopted or sought those skills require even greater attention and investment.

In an effort to provide some hints and guidelines for developing an ethnic sensitive preventive practice, a problem potentially attended by each of the approaches previously identified is discussed below.

HEALTH PROMOTION

Enormous speculation, theorizing, and research have failed to identify the exact reasons why ethnic minority individuals, especially adult males, use drugs in excess. Yet there appears to be sufficient evidence to conclude that associated precipitating factors include availability, peer pressure to experiment, emotional responses to racism and discrimination, limited self-respect and efforts to combat depression and related emotions. Irrespective of the associated precipitating factors, the outcome of continued use – including the physical deterioration of the individual user contrasted with the frequent delinquent activities to secure funds to support the habit, the utilization (and often creation) of abandoned buildings as shooting galleries and the subtle or overt encouragement of uninitiated abusers – all combine to make drug abuse, at once, an important and social/emotional problem.

Given this fact, a relevant program aimed at preventing drug abuse through health promotion might well include early educa-

tional efforts at grade school level designed to encourage realistic understanding of the effects of various types of drug abuse leading to individual decision making. Related preventive efforts should include the identification or creation of opportunities which enable the community to experience its own effectiveness in confronting the problem of drug abuse by a significant portion of inhabitants in ethnic minority communities. In this respect a community must be encouraged and enabled to control availability of drugs within its boundaries, eliminate the spaces that house the expression of this habit, lobby for increased fiscal and supportive resources from governmental bodies, and create a climate that discourages drug use as a substitute for self worth. Simultaneously the community must be encouraged to express a caring – albeit deterrent – attitude toward established drug users while developing a critical sense of empowerment related to improving the social and physical environment and ultimately preventing increased drug abuse.

HEALTH PROTECTION

The position taken in this chapter is that many diseases are preventable given our current knowledge and resources. Yet in many ethnic minority communities a range of diseases associated with poverty flourish for a number of reasons – some directly related to the ethnic minority group in question and others related to society and the institutions it has created and to which it has assigned responsibility for coping with these problems.

For example, bacterial and parasitic diseases and tuberculosis – diseases obviously related to overcrowding, inadequate housing, lack of pure water and poor nutrition – continue to ravage Mexican American and other ethnic minority communities.[31] Education and the dissemination of information regarding these specific diseases, how they develop and spread and their preventability will go a long way toward decreasing the rates of these diseases in the above mentioned communities. Activities carried out by public health organizations are even more effective. Consequently a health protection approach to prevention should include a sharper increase of public health efforts; a firmer and more aggressive confrontation of the challenge and responsibilities; the organization of services designed to eliminate the low utilization of facilities by ethnic minority groups; an understanding and appreciation of the impact of differing conceptions of illness and alternative sources of care in ethnic minority communities; and a greater recognition

and implementation of cultural factors in the delivery of preventive services.

DISEASE PREVENTION

Strategies derived from an analysis of risk factors can best be understood through a discussion of sickle cell anemia, a disease that primarily affects Blacks and Puerto Rican infants. Sickling has also been reported in American Indians and in non-United States inhabitants. It may be speculated that a systematic and successful approach to preventing this disease is lacking because it has not been considered a major or priority social/health problem. Nevertheless some ethnic minority physicians at Howard University, at Meharry Medical Center and other Black institutions have made this disease a research priority, which should ultimately fill the knowledge/treatment gap.

In the meanwhile, prevention in the form of active and extensive screening, good clinical management, and informed genetic counseling are practices to which social workers can contribute significantly need to be implemented. Similarly, social workers can and should advocate in those situations where sterilization and/or abortion of women with sickle cell traits or disease are routinely recommended without adequate and accurate consideration of the implications and of the interests and concerns of the respective women. Prevention, in this and other health care situations, must be considered as one aspect of the general objective to obtain the best maternal and child health outcomes in ethnic minority families.

Conclusion

The current view is that prevention is an idea whose time has come. This view is only partially correct, since prevention has concerned practitioners in the fields of physical and mental health for centuries. Proponents of this viewpoint are correct, however, in their assessment of the current interest and the growing commitment of practitioners, legislators and the general public in prevention. Although there have been enormous gains in the prevention of infectious diseases, and although large numbers of minority persons have benefited from public efforts in sanitation and immunization, the special interests and problems confronting minority communities have not captured the attention of practitioners. Less is known about prevention in the field of mental health, although

the interest in this goal is parallel to developments in the area of physical health. Time will tell if this interest leads to substantive and pertinent preventive measures and, similarly, if the mental health concerns of minority persons benefit strategically from these developments and/or are given any semblance of priority.

For decades minority individuals and communities have been concerned with simple survival. More recently these individuals and communities, based on their personal criteria, appear ready and able to move beyond survival toward the achievement of goals of a higher order. Prevention of physical and mental health problems are among these goals, infused with the determination that future generations of minority people will not suffer or experience the ravages from preventable social and physical stimuli. Achievement of these objectives, at any level, will depend on many factors, not the least of which are the knowledge to control disease, the will to invest resources, the courage of practitioners to confront this task and the responsibility of minorities – individuals and communities alike – to demand and subsequently utilize these resources.

Notes

1. Richard H. Price, Richard Detterer, Barbara C. Bader, and John Monahan, *Prevention in Mental Health: Research Policy and Practice* (Beverly Hills, Calif.: Sage Publications, 1980).
2. Martin Bloom, *Primary Prevention: The Possible Science*, (Englewood Cliffs, N.J.: Prentice Hall, 1981).
3. Rodney M. Coe, *Sociology of Medicine* (New York: McGraw Hill Book Co., 1978).
4. *Ibid.*, p. 183.
5. Duncan W. Clark, *A Vocabulary for Preventive Medicine* in Duncan W. Clark and Brian MacMahon (eds.) *Preventive Medicine* Boston: Little, Brown and Co. 1967.
6. Coe, *op. cit.*
7. Ruth Caplan, *Psychiatry and the Community in Nineteenth Century America* (New York: Basic Books, 1969).
8. *Ibid.*
9. *Ibid.*
10. *Ibid.*
11. Coe, *op. cit.*
12. Bernard L. Bloom *Community Mental Health: A General Introduction* (Monterey, Calif.: Brooks/Cole Publ. Co., 1975).
13. Anthony Broskowsk, Edward Marks, and Simon H. Budman eds., *Linking Health and Mental Health* (Beverly Hills, Calif.: Sage Publications, 1981).
14. Emory L. Cowen, "Primary Prevention Misunderstood", *Social Policy*, Vol. 7 No. 5 (March/April 1977), pp. 20-27.
15. Task Panel on Prevention, Commission on Mental Health, *Report to the President*, Vol. 4 (Washington, D.C.: U.S. Government Printing Office, 1978).
16. *ADAMHA Prevention Policy Paper*, (Washington, D.C.: Office of the Administrator, Office of Program Planning and Coordination/Division of Prevention ADAMHA, 1979).
17. Wynetta Devore and Elfriede G. Schlesinger, *Ethnic Sensitive Social Work Practice* (St. Louis, Mo.: C. V. Mosby Co., 1981), p. 152.

18. Jacquelyne Johnson Jackson, "Urban Black Americans," in *Ethnicity and Medical Care*, ed. Alan Harwood (Cambridge, Mass.: Harvard University Press, 1981).

19. B. S. Dohrenwend and B. P. Dohrenwend, eds. *Stressful Life Events: Their Nature and Effects* (New York: John Wiley, 1974).

20. Bernard L. Bloom, "Prevention of Mental Disorders: Recent Advances in Theory and Practice," *Community Mental Health Journal*, Vol. 15 (1979). pp. 179-91.

21. Barbara Bryant Solomon, *Black Empowerment: Social Work in Oppressed Communities* (New York: Columbia University Press, 1976).

22. Jackson, *op. cit.*

23. Herbert Hendlin *Suicide: The Psychosocial Dimension Suicide and Life Threatening Behavior*, 8, 1979. pp. 99-117.

24. Alan Harwood, "Mainland Puerto Ricans" in *Ethnicity and Medical Care*, ed. Alan Harwood (Cambridge, Mass.: Harvard University Press, 1981).

25. Janet M. Schreiber and John P. Homiak, "Mexican Americans," *Ibid.*

26. *Task Panel Reports*, Vol. III, Submitted to the President's Commission on Mental Health (Washington, D.C.: U.S. Government Printing Office, 1978).

27. Leona L. Bachrach, *Utilization of State and County Mental Hospitals by Spanish Americans in 1972* (Rockville, Md.: National Institute of Mental Health, Division of Biometry, June 1975, (Statistical Note No. 116).

28. Bloom, *op. cit.*

29. Samuel O. Miller, "Clinical Social Work in Cross Cultural Contexts" (Prepared for publication in the *Handbook of Clinical Social Work*, in press).

30. Charles A. Pinderhughes, "Racism and Psychotherapy," in *Racism and Mental Health*, ed. C. Willie, B. Kramer and B. Brown (Pittsburgh, Pa.: University of Pittsburgh Press, 1973).

31. Donald C. Klein and Stephen E. Goldston eds., *Primary Prevention: An Idea Whose Time Has Come*. (Washington, D.C., U.S. Government Printing Office, 1977). See also *Task Panel Report* to the President's Commission on Mental Health, *op. cit.*

5

Education for Primary Prevention Practice with Ethnic Minorities

James W. Leigh

The past 40 years have been marked by swift events of a critical nature in the United States. Since World War II, the Korean and Vietnamese Wars, the Peace Movement, Watergate, the public assassinations of Martin Luther King, Malcolm X and the Kennedy brothers, the Civil Rights Movement and the Women's Equal Rights Movement have necessitated rapid readjustments and adaptations to national crisis situations. Traumatic in nature and critical in content, these events were complicated and often confusing to the public. They were also symptoms of evolutionary changes occurring in society. Changes were advocated in political, racial, sexual, and generational relationships. A variety of patterns of life have resulted. Many persons were able to adapt to new social and political roles. Other persons encountered problems as a result of the rapid demands for change. Many of the latter group came to require social services to support and guide their quest for satisfactory relationships with self, family, and societal systems.

Social work as a professional discipline concerned with the interaction between people and their environment operates on the basis that people can be assisted in surviving the social and psychological stress of change. Included in the values of social work is the emancipatory ideal that argues that the individual can adapt to or change functional or structural situations in order to pursue paths of fulfillment. The emancipatory ideal forms the base for helping procedures and must be recognized in teaching related to prevention of personal and community problems of minority populations.

Concern with social services to minority populations generally has been given increasing recognition by social work education in the past ten years. By acknowledging the effects of society and system issues on minority groups, social work education attempts to answer the ethical practice issue of "Who shall survive when not all can survive?"[1] The inclusion of minority content in curricula of schools of social work means that social work as a profession believes that minority populations should survive and that an ethical and value stance in this regard has been taken. Crucial decisions affecting minority populations in the United States will rest upon such ethical practice issues as well as values of the social work profession.

In addition to the teaching of content about minority populations and methods of assisting minority persons, families and groups congruent with culture, life style, and world views, social work education needs to introduce content and methods related to primary prevention for mental health with minority populations. The prevention of personal dysfunction within minority groups is important to their survival.

This chapter will focus on the field practicum as an educational course for introducing content related to the practice of primary prevention with minority populations. The educational setting within which practicum education is received will first be examined. As social work practice is informed interventions, knowledge which educators need to be sensitive to will be discussed from a life-span continuum form. In addition, the issue of ethnicity and race as causative agents for problems identified in minority communities will be discussed. Suggested activities for practicum experiences which may be helpful are presented. The role of the educator in primary prevention activities and programs with minority populations is a vital area for consideration as part of practicum education. A brief description of a family life education

course and discussion of two identified areas of prevention are presented as examples. Recommendations for practicum educators who wish to incorporate the suggested primary prevention content and practice experience close the paper.

The practicum is the major experimental component of the social work curriculum. As a curriculum component, the practicum is a course having goals, objectives, and specific content. In an earlier paper, this author delineated the necessity of including ethnic minority content into the practicum.[2] Integrating primary prevention content for mental health practice would expand the existing practicum curriculum. The practicum experience provides a setting in which the creation, engineering, implementation, and direct practice of primary prevention activities can be introduced.

Primary prevention in mental health involves activities on the part of the social worker to assist minority persons to survive and transcend personal and social change in order to find fulfillment in social life. These activities are essentially of an educative nature and can be of two types. The first type is consultation to community agencies staff and organizations who state a need to obtain more knowledge about a given population or problem. The second type is the provision of prevention services directly to the population viewed as at risk or vulnerable to social, medical, and mental health problems in the future.

The major objective of mental health prevention endeavors is to change attitudes and behaviors by sharing information and imparting knowledge. Minorities historically have viewed education as a means for emancipation from economic, social, and political oppression. The knowledge gained in the educational process provided the path to social mobility. Civil behaviors were an accepted result.[3] Knowledge leading to behaviors that protected the minority person from the effects of racism in all aspects of life became a guiding family focus.

Becoming educated involves learning from those who are teachers. In teaching, one attempts to deliver knowledge for others to learn before using the knowledge in social behavior, politics, economics, and personal relationships. Learning empowers one to control the environment, psychologically and socially, through active thinking processes that determine actions or reactions to inner and outer stimulation.

Few social work practice theories encourage social workers to become primarily an educator within the helping relationship. In

the area of primary prevention, the role of educator is basic and must be understood if prevention is to be a viable goal of our work with minority persons, families, and communities.

The Educational Setting

Education for the practice of social work occurs within accepted and certified programs either at the undergraduate or graduate level. The ultimate objectives of social work education are for the development, administration, and provision of social welfare services through competent personnel. Social work educators are responsible for teaching content and procedures of practice that enable practitioners to deliver social services within the mandate of institutional settings such as medical services, child welfare services, mental health services, family services, and correctional services. There exists wide variations in educational programs reflecting differences in regional populations and methods considered appropriate to meet the service needs of the populations.

The Civil Rights Movement of the 1960s provided the impetus for an examination of the relevancy of social work education to minority populations. The content and methods taught by social work educators to social work students were questioned. Traditional individualistic approaches characterized by casework education were believed to hold the individual responsible for the problems presented; the strengths of minority families were ignored and the cultural institutions of minority groups were not utilized in social work helping efforts. These were areas of criticism related to social work education and social work practice.[4] In addition, the focus on rehabilitation rather than prevention services prevailed.

Within the educational training period, the student is socialized to the objectives, methods, and goals of a profession. The socialization process within social work education has been given little attention. Bucher and Stelling's important study concludes the "outcomes of socialization are, in large part, determined by the nature of the training program."[5] The absence of a primary focus on prevention in content and experiences in the field practicum represents a barrier to the total socialization process.

The training phase of any profession is crucial to future professional practice. Knowledge taught and activities engaged in are the basis of services for the future. If preventive services and pro-

grams to minority populations are not an integral aspect of the social work educational thrust, the social work student will not view them as important.

Fred Howcutt, a former community mental health center director, states that the results of the absence of a primary prevention focus in social work education produces the following areas of concern:

1. Social workers seem not to be comfortable working in minority communities or with minority persons unless these services are given in the agency. Primary prevention activities involve outreach services to populations at risk – not those persons identified as having a problem for which agency services are requested or mandated.
2. The concept of self-determination is not understood as an operating concept on a community level.
3. Clinical services are viewed narrowly in the sense that only rehabilitation counseling services are clinical.
4. The social worker does not see the true connection between the individual, the family, and the community. In regards to minority populations, negative and positive attributes must be noted. A focus on culture and life styles can result in a lack of effort on the part of the social worker to assist in improving conditions in minority communities. Students must be educated to look into, not at, situations to make correct assessments and decide on how situations can develop into pathological conditions and, in concert, with the community, begin to develop preventative programs. The value of projected thinking is that it allows one to conceptualize what is observed. Social workers are thought to enter professional practice without an ability to engage in projected thinking and thus are handicapped when involved in primary prevention programs.
5. The social worker does not think about or utilize nontraditional community resources. In addition to traditional resources, the social worker who works in primary prevention in minority communities should know how churches and individual community persons serve to alleviate and prevent stress on community members. At times, the finding of a nontraditional resource dem-

> onstrates to a person and the community the caring aspect of preventative services. The social worker working in minority communities needs the skill of discovering how a community can help itself and its individual members to survive. This may mean interventions which focus on bringing people with skills to trade services each may need for daily survival. The social worker, for example, could broker a person with carpentry skills to do home repair for an elderly person who might provide parent relief services to the carpenter's family.[6]

Attention to the potential results by social work educators will aid practitioners in the development of a professional identity which has as its core a sense of responsibility to minority populations. Towle states "responsible, intelligent professional help must increasingly be oriented to the individual in the context of his social situation, with perception of what the service is doing to the person while doing something for the person."[7]

To achieve professional responsibility in training programs as it relates to minority populations, prevention knowledge and practice skills need to include content which when related to prevention methodologies will prepare the practitioner for effective preventative work with minority persons. Courses and content must relate to the knowledge needed and necessary methods and skills appropriate to engage in primary prevention for mental health successfully.

Three levels of prevention are generally accepted: primary, secondary, and tertiary. Primary prevention entails health promotion and specific protection. Caplan defines primary prevention as "the lowering of the rate of new cases of mental disorder in a population over a certain period of time by counteracting harmful circumstances before they have a chance to produce illness."[8] Primary prevention is geared to the reduction of risk for a population, rather than preventing a specific person from becoming ill. Secondary prevention entails early diagnosis and prompt treatment. Tertiary prevention is disability limitation and rehabilitation. This latter area of prevention encompasses the major area of social work education and training.

Inclusion of primary prevention content for mental health promotion into the curriculum must recognize that two major restraints are present. The first is that primary prevention calls for an extended time frame because target problems in question are

generally those that change only slowly over time. In the field of corrections, concern with rising rates of reported crime in minority communities that result in primary prevention programs may not quickly reach a point where the program is known to decrease the crime rate. A second restraint is that knowing about the area of primary prevention systems is different from having personal, administrative, and institutional capabilities for facilitating health-promoting programs.[9] An agency may have neither practitioners with skills nor interest in primary prevention nor an administrative structure and mandate to offer such services, even though knowledge about primary prevention does exist.

The Knowledge Base

The practitioner, prior to engaging in primary prevention activities, must know about and be sensitive to minority individuals, families, and communities. This knowledge forms the basis for assessment and has immediate implications for decisions regarding services to reduce identified problem occurrences. Rates of problem occurrences must be compared over time. Where alcoholism, mental illness, suicide, homicide, delinquency, birth rates, death rates, divorce rates, and welfare dependency are believed to be problem areas in a group or subgroup, the practitioner must consider and analyze the increasing, decreasing, or stable rates of occurrence over time.

The literature on problem occurrence in minority populations appears to center in several areas: structural unemployment, the rise in suicides, homicides, infant mortality rates, diagnosed cases of depression, and the rise in the number of dependent children. When the factor of causation is considered, poverty, impoverishment, and the oppressive social conditions resulting from institutional racism are generally accepted reasons. While it is difficult to adhere to a single theory of causation, all multiple causation considerations include racism and its effect on minority populations.

In planning preventive strategies, the practitioner might attend to Wittman's statement, "We need to consider the points of entry where social workers may be particularly effective."[10] What are the points of entry when considering minority populations? Viewing the lifespan continuum of a minority person may be helpful if one takes into consideration social factors that become cru-

cial at any given developmental stage. For example, between the ages of 12 and 15, minority children, particularly males, seek part-time employment. For many Black children, part-time employment begins at a much earlier age. (The fact that a number of the Black male children murdered in Atlanta, Georgia, were bag boys in supermarket parking lots is illustrative of this point.) Seeking part-time employment may be a child's first real and unprotected brush with discrimination in employment. A negative experience can be unprepared for, traumatic, and may result in threatening or decreasing self-confidence and self-esteem. Educational motivation may be lowered if the child comes to believe that education will not lead to employment. Racism in society will affect a child's beginning employment even if the child is protected by the family. Gilliam reports the story of a 17-year-old Black girl, a high school graduate, who obtained a job as a home health aide. On her first assignment, the white woman she was to care for refused to let her enter saying, "I can't handle this, this is a white home." The young girl's first encounter with racism was crushing.[11]

Infant mortality rates in minority communities are of current concern to public health persons. The city of Detroit's Black infant mortality rate illustrates this fact. A Black infant born in Detroit in 1980 was 2½ times as likely to die during infancy as a white child. The number of Black pregnant women who saw a doctor five or fewer times before giving birth in 1980 was twice as high as the state of Michigan average and 76 percent higher than the rate for the city's white pregnant women.[12] The problem is viewed as not only racial but social and economic as the Black pregnant woman who loses her child in infancy does so due to poverty, poor nutrition, and a distrust and fear of doctors and hospitals which become part of an attitude that has its roots in society's relationship to the Black population.

Prenatal and postnatal care is related to the minority groups' economic status, housing, and the manner in which the larger society relates to and provides accessible health services to minority women. A preventive educational program would have to include information about the larger society's definition, views, and manner of relating to ethnic minority pregnant women and their children. These definitions, views, and manner of relating will affect the health of mothers and children. A preventive program addressed to the reduction of infant mortality rates in minority communities would have to consider multicausal factors and how to offset them through direct prevention services with pregnant

minority women.

The ethnicity and race of minority couples also may be a critical element in rising minority group divorce rates since 1970. A U.S. Department of Commerce report indicates that the divorce ratio for Black women more than doubled from 1970 rising from 104 to 257 divorced women per 1,000 married women living with their spouse.[13] The combined divorce ratio for Black men and women (203 per 1,000) was almost double those for white persons and persons of Spanish origin (92 and 94 respectively). The increased divorce rates resulted in an increase in Black children under the age of 18 living with one parent. In 1970, 32 percent of Black children lived with one parent; in 1980, 46 percent of Black children lived with one parent.[14]

The implications of these statistics for primary prevention programs in the Black community are far reaching. Minority group status in the area of employment, education, and the provision of basic human needs has been a determinant of family stability. The stress of unemployment on marital relationships and on child rearing practices has frequently been held forth as a prime cause of marital problems. The changing roles of Black women and men along with the demands for equal status of Black women have also been cited as reasons for the rising divorce rates.

Primary prevention services geared to minority adolescents may enhance the communication between men and women at some future point and may be helpful in meeting this particular problem of family breakdown and assist in reversing the trend towards a weakening of the Black family unit through divorce. Jeff suggests that the society in which we live is predicated on the nuclear family and when "high rates of infant mortality, unemployment, high prison rates, and high rates of homicide are present the one-man, one-woman ratio is severely altered if not destroyed."[15] Under such conditions a commitment to love and perpetuate the race is a burden. Primary prevention services to minority couples prior to marriage would assist in their understanding of the forces which will work against marital stability.

A fourth area of concern in which ethnicity and race may be a causal factor is that of minority inner group crime. Inner group homicides which are viewed in many instances as impulsive, unprovoked, and resulting from unchanneled instinctual drives, may have a provocation when examined from an ethnic minority view that is informed by an accumulation of stress resulting from an ever-imminent state of social apprehension due to minority group

status and negative identification by the larger society. The state of oppression in which minority persons reside results in severe prohibitions against aggression being directed towards the majority group. Black persons, for instance, learn early that it is safer to commit an aggressive act on another Black person than on a white person. An awareness of the oppressive mechanisms at work which make it safer and easier to exact violence on minority group members may well be on one avenue of prevention of this growing community problem.

Preventative social work would ideally address itself to the education of students and the public about the psychological and social consequences of factors believed to cause personal and social problems for minority persons. Educators might encourage students to consider alternative structures which would stress preventive activities not only with the public, clients, and communities but also with other professional social work practitioners. The question must be raised in the educational process as to the difference it would make to a family or individual if the community environment continues to contain the seeds of dysfunctional states. This may be the ultimate in preventive social work teaching. Preventive thinking relative to ethnic minority populations must consider the etiological factors in the process of initiating primary interventive strategies.

All delivery systems introduced into the training of social workers should include a preventive intervention concept which would assist the student in becoming aware of these harmful influences in the environment.[16] With this focus, the student becomes alert to the importance of exploring social problems not only in the arena of emotional difficulties but as to their implications for work with minority persons in prevention activities. Movement from the case to cause thus would be facilitated and would aid in the student's understanding of the need for social institutions and agencies to develop strategies utilizing case data for reforms in social policy and social legislation.[17]

The practitioner must look at the various stages of development and needed task accomplishments through the conceptual screen of being a minority person of color. The initiation of services with an educational focus prior to developmental tasks may set the stage for personal empowerment. Primary prevention services have the potential to heighten awareness and knowledge of social realities resulting in the reduction of personal feelings of hopelessness, helplessness, and powerlessness.

The Field Practicum

The social worker engaged in mental health prevention activities has the primary role function of teacher. This role is among several that social workers assume in the delivery of social services. Mediator, counselor, mentor, advocate, and change agent are additional roles identified as important for service delivery to minority populations. They are all learned in the practicum.

A prevention approach that can be easily integrated into the practicum is that of designing and implementing a program which consciously presents minority role models to minority youth.

McDaniel views the presentation of successful role models as sources of motivation and identification among Black youth.[18] Prior to the civil rights movements of the 1960s, Black role models were readily visible to Black youth but due to legal integration, Black successful role models are not visible enough to serve the needs of striving youth. By such exposure Black youth can be provided with a means of developing positive attitudes toward success, learn the criteria for success, and develop the critical skills necessary for achieving success.

Black role models are felt to have a positive effect on Black youths' success in educational settings by decreasing the growing Black youth school drop-out rates, and raising the declining Black scholastic performance rates. Social work students could be asked to read, review, and analyze autobiographical literature of minority men and women who are successful in a variety of fields of endeavor. Thus an opportunity is present to draw on the life experiences of minority persons as indicators of issues in the life span development as they relate to both social and psychological development and the management of incremental environmental stress.[19]

What kind of preventive intervention might be needed with a group of Black youth to prevent delinquent behavior? McDaniel suggests two approaches: the first would be interacting with Black professionals with the goal in mind of involving them with Black youth through accepting Black youths as interns, part-time workers, or observers. The second program would be to facilitate routine formal and informal interaction between Black youth and Black role models.[20]

These approaches in McDaniel's model would involve micro and macro social work knowledge and skills, particularly as they relate to counseling, communication, and community organiza-

tions. The approaches are preventive in that they attempt to concentrate on service delivery prior to the onset of problems. The students need not be those referred for problematic behavior.

The field practicum educator might utilize the case discussion method of teaching to introduce factors related to mental health prevention activities in elementary and secondary schools. For example:

> A Black male social worker was invited to speak to an elementary school class as part of a career day program. The invitation requested the social worker to address the topic of what a social worker did as an administrative aide to a city council person. The speaker is a Black male, 44 years of age.
>
> The class consisted of 25 Black sixth grade children. The students were sitting with their heads down at desks. The lights in the room were out. The teacher explained the class might not be receptive; it had been a bad day for her. She turned on the lights and briefly introduced the speaker and admonished the children to pay attention. The children raised their heads to look at the social worker standing in front of them.

In this type of case, a social work student could address mental health prevention as a specific role model, or as one who implements role model activities with school pupils. This opportunity would utilize knowledge of communication and group dynamics and ethnic minority content. Role model activities present career awareness information that can be supported by cross cultural data on Black and other minority group representatives in various occupations. Group discussion about role models and how to proceed toward career goals would be the outcome of this service strategy.

On another level, the classroom teacher may determine that a social worker's consultation services are warranted to evaluate the class's behavior and to plan for encouraging and motivating an apathetic group toward educational and vocational achievement. By using illustrations from practice, the field practicum educator can guide social work students to relevant literature which can inform practice with minority populations. Gaps in student knowledge can be identified as they relate to forming relationships with minority populations.

The field practicum provides the student with an opportunity to engage in role-playing activities. Role playing is the practicing at (or playing at) being professional. To the student role playing is of primary importance in the development of professional identity.

and commitment.[21] The tasks assigned for students must give them a sense of mastery of an activity or knowledge that is in the "particular domain" of the profession. The student considers these tasks as important only if they observe other professionals around them learning or performing similar tasks and evaluating them.[22] The student incorporates such activity through extensive supervision and a certainty that the activity is an important component of the work of the professionals they observe and with whom they interact.

Innovative field practicum placements have been reported.[23] Placement in the office of a public elected official has potential for direct prevention service activity. The consultation experience as well as research, social policy analysis, and planning are integral learning experiences for students. The primary prevention and education experiences are illustrated in the following case sample:

> Mrs. Humphries decided to contact the office after she heard a campaign speech by the council person in which she invited persons with problems to call the office. When I introduced myself to her she said "Thank you, Jesus." Mrs. Humphries was 72 years of age, a widow who was raising a 15-year-old girl for whom she had been receiving financial assistance under a state program of financial aid to persons who were legal guardians of minor children. Mrs. Humphries had not received a check in two months and was under severe stress as she felt her parenting of the girl was being questioned.
>
> In the course of our interviews, the federal cutbacks on financial aid to states was explained. This served to relieve the stress Mrs. Humphries had internalized creating anxiety and feelings that she was not a good mother.
>
> Information sharing became a focus of the work with Mrs. Humphries and she began to use our contacts to "learn about how that place works." Mrs. Humphries, through the knowledge gained, was able to consider options she had to do her own problem solving: how to approach persons in social systems to obtain the services she was entitled to, how to utilize her strengths as a Black person rather than focus on weaknesses defined by the society, and use agencies in the community that focused on the needs of the aging Black person.

Recommendations for Field Practicum Educators

Field placements offer a variety of settings for developing and implementing innovative mental health prevention strategies.

Mental health prevention requires the social worker to learn and utilize the role of educator. Family life education, a strategy for mental health promotion that generally has not been encouraged by schools of social work, is a viable prevention activity for minority communities. Its use in many social and community mental health agencies is widely accepted. According to Ambrosino, "The social worker who provides family life education is invariably trained by agencies to perform such services rather than by schools of social work."[24] However, an exception is presented by an elective course in "Family Life Education" at the University of Washington School of Social Work. Students have the opportunity to transfer this class learning into direct practice.

The objective of the course in "Family Life Education" is to encourage social work students to gain beginning skills in leading groups that have an education focus to prevent problems in family life and personal development. It is believed that education and information sharing within the context of a dynamic group approach should become a viable approach within broad community mental health services. This approach emphasizes cognition as a major factor in empowering persons to manage life stress.

Along with a broad overview of the conceptual framework for family life education, specific skills are taught such as learning leadership styles, giving a lecture, managing the dynamics of the group process, and the ability to lead group discussions which are ego-enhancing for the group members. Administrative issues are presented such as determining community need through community needs assessment, advertising, fees charged, size of groups for optimal learning and location of the service. Family Life Education approaches would be useful in assisting many minority persons identified as alcoholics in becoming functional persons. The provisions of ways in which the minority person can "confront themselves, face their problems and take responsibility for self with the help of supporting persons is believed to be one method of reducing the addiction rates within the Black community."[25]

Overall, given a correct assessment by a skilled practitioner, education and information sharing can become the treatment of choice with many minority persons. This treatment approach, as outlined by Mathis should:

1. Pose and stimulate questions for active reflective consideration.

2. Help to evaluate current ideas, attitudes and knowledge base.
3. Provide information, direction, guidance, resources, instruction and new knowledge or preceptions when there are perceived gaps or lacks.
4. Encourage, foster and support identifiable ego strengths.
5. Provide information for alternative choices of behavior.[26]

Sharing information and education has generally been a specialized service within social and mental health agencies. Practitioners who have an interest in educational activities become consultants to other social institutions and offer information services through public speaking. As many minority families utilize television as a prime source of leisure time activity, primary prevention programs of the future might well consider television programming as a vehicle for reaching populations at risk. Awareness of personal, family, and community problems screened through a mental health framework might have an important impact on the reduction of social and personal problems. The growth of cable television in the United States and the use of community public access channels should be explored as to their applicability for primary prevention programs.

The implications of the Bucher and Stelling study for primary prevention with minority populations are extensive. First, no matter what the intent of our planned prevention learning experiences in the practicum, the tasks must be important and performed by the agency professional staff. Mere exposure to preventive content regarding minorities in the curriculum will not assure that students will incorporate the activity into their professional identity without practicum supervision of an extensive nature. Educators introducing prevention content and methods as a means of helping minority populations need not only look at the curriculum content in the various sequences like Human Behavior and the Social Environment, Research Methods, and Social Welfare Policy and Planning, but also how the practicum of the student utilizes classroom material in the field. Exposure to new and innovative approaches to thinking about minority populations may have little impact on the student unless also introduced into the practicum as a valued activity.

Primary prevention services with and for minority populations currently receives scant attention in the education of social

workers for professional practice in social and community mental health agencies. The preparation for prevention work with minority populations must begin with the educational process in the classroom and the practicum. Information taught can view the life developmental span of minority populations and the effects on developmental tasks of living in a social environment which does not readily accept minority group members. The effects of race, racism, and institutional racism must be understood by the student as these factors may be causative to any problem area of concern. Social work educators have the responsibility of educating practitioners who will view primary prevention intervention as a valued professional activity. Social work educators must include ethnic minority and primary prevention content in social work courses to increase sensitivity and understanding of minority populations which in turn, intelligently informs mental health practice approaches.

Notes

1. Harold Lewis, "What Is To Be Done? Social Work Educators in the 80s" (New York: Hunter College of the City University of New York, 1982), p. 26. (Originally an address at the Opening Plenary Session, Council on Social Work Education Annual Program Meeting, New York, March 8, 1982.)
2. James W. Leigh, "Ethnic Content in Field Instruction," in *Black Perspectives on Social Work Education* (New York: Council on Social Work Education, New York, 1974), pp. 51-61.
3. Charles V. Willie, *Black and White Middle Class Families: What They Can Teach and Learn From Each Other.* Paper presented at the Council on Social Work Education Annual Program Meeting, Boston, Mass., March 7, 1979.
4. James W. Leigh and James W. Green, "The Structure of the Black Community: The Knowledge Base for Social Services," in *Cultural Awareness in the Human Services*, ed. James W. Green. (Englewood Cliffs, N.J.: Prentice-Hall, 1982), pp. 97-100.
5. Rue Bucher and Joan G. Stelling, *Becoming Professional*, Sage Library of Social Research, Vol. 46 (Beverly Hills, Calif.: Sage Publishing Co., 1977), p. 257.
6. Fred Howcott, Former Director, Neighborhood Service Organization, Community Mental Health Center, Detroit, Michigan, Personal interview, May 25, 1982.
7. Charlotte Towle, *The Learner in Education for the Professions.* (Chicago, Ill.: The University of Chicago Press, 1954), p. 3.
8. Gerald Caplan, *Principles of Preventive Psychiatry* (New York: Basic Books, 1964), p. 26.
9. Emory L. Cowan, "Primary Prevention Misunderstood," *Social Policy*, Vol. 7 (March/April 1977), pp. 20-27.
10. Milton Wittman, "Preventative Social Work: A Goal for Practice and Education," *Social Work*, Vol. 6 (January 1961), p. 23.
11. Dorothy Butler Gilliam, "Getting Ready for the Real World," *The National Leader*, July 1, 1982, p. 17.
12. Stephen Franklin, "Poverty and Pregnancy," *The Detroit Free Press*, May 24, 1982, pp. 1-2D.
13. *Marital Status and Living Arrangements, March 1980.* (Washington, D.C.: U.S. Department of Commerce, Bureau of the Census, October, 1981), p. 2.
14. *Ibid.* p. 31.
15. Morris F. X. Jeff, Jr., "Homicide Among Black Men and Women," *Black Male/Female Relationships*, (Winter 1982), p. 11.
16. Ian A. Canion, Brian F. Early, and Lloyd H. Rogler, *The Puerto Rican Child in New York City: Stress and Mental Health.* (New York: Hispanic Research Center, Fordham University, 1980), p. 101.

17. Salvatore Ambrosino, "Integrating Services for Health Promotion" in *Primary Prevention in Mental Health and Social Work: A Source Book of Curriculum and Teaching Materials*, ed. Milton Nobel. (New York: Council on Social Work Education, 1981).

18. Clyde O. MacDaniel, "Black Success Role Models: Implications for Social Work in the 1980s," *Black Caucus*, Vol. 13 (Spring 1982), pp. 19-24.

19. Arthur Ashe, *Off The Court* (New York: New American Library, 1981); E. Frederic Morrow, *Forty Years a Guinea Pig* (New York: Pilgrim Press, 1980); Richard Rodriquez, *Hunger of Memory: The Education of Richard Rodriquez* (Boston, Mass.: David R. Godine, 1981); Alice Walker, *You Can't Keep A Good Woman Down* (New York: Harcourt, Brace Jovanovich, First Harvest Edition, 1982); and David Bradley, "Black and American, 1982," *Esquire*, May 1982, pp. 58-71.

20. MacDaniel, *op. cit.*, p. 23.

21. Bucher and Stelling, *op. cit.*, p. 266.

22. *Ibid*, p. 266.

23. Nell Lipscomb, "The Teaching-Learning Setting in a First-Year Field Instruction Program," in *The Dynamics of Field Instruction: Learning Through Doing*, (New York: Council on Social Work Education, 1975); Shirley J. Jones, "New Teachers Settings and Their Reference for Social Work Education," *Social Work Education Reporter*, Vol. 20 (April-May 1972), pp. 52-56; and Franklin M. Zweig, "The Social Worker as Ombudsman" in *Social Workers at Work*, ed. Tony Tripoli, Philip Fellin, Irvin Epstein and Roger Lind. (Itasca, Illinois: F. E. Peacock Publishers, 1972).

24. Ambrosino, *op. cit.*, p. 7.

25. James W. Leigh, "Family Life Education" in *Manual of Course Outlines in Primary Prevention in Mental Health and Social Work*, ed. Milton Nobel. (New York: Council on Social Work Education, 1981), pp. 75-88; and Sylvia R. McMillan, "Alcohol: A Weapon of Black Genocide," *Urban Research Review*, Vol. 7 No. 4 (1981), pp. 1-6.

26. LaVerte R. Mathis, "Education and Information Sharing with Black Clientele", *Key Mental Health Issues in the Black Community*, Lawrence E. Gary, ed. (Washington, D.C.: Institute for Urban Affairs and Research, Howard University, 1976), Vol. 3, No. 1. p. 41.

6

Prevention Among the Minority Elderly

David Maldonado

Aging is a universal phenomenon. It is a fact of life that affects individuals and groups from all racial and cultural backgrounds. Yet, it is a phenomenon that is experienced differently among the various groups, especially between the minority and the nonminority populations to such an extent that the minority elderly have been described as being in extra jeopardy and at risk.[1] Not only do minority persons have to face the challenges of aging per se, but their aging experience is compounded by the fact of their minority status and their minority experience in previous stages of life. The result is an aged minority population with special experiences and predicaments that present anticipated dangers, as well as potential strengths. This chapter explores the experiences of the minority elderly that explain not only the current dangers but also provide opportunities for successfully facing these dangers in a preventive manner.

The phrase "minority" is used to distinguish between the white or European and those populations that have been traditionally perceived as minority." [2] These populations can also be described as the people of color (nonwhite); more specifically these include Blacks, Hispanics, Asians and Native Americans (American Indians). Historically, these groups have been distinguished primarily by racial characteristics, maintenance of cultural differences, and lower socioeconomic status in this country. The term "minority" does not refer to a "lesser" or "lower" culture or race, but rather to the perception that they are not fully acculturated and assimilated into the dominant white Anglo social structures. Generally, these minority populations are also a minority in numbers, yet in certain areas of the country, especially in urban settings, the minorities are actually the majority population. For the purpose of this discussion, however, "minority" will refer to the status of being different and not a part of the dominant white population.

Interest in the minority elderly is a relatively new phenomenon. Minority populations have traditionally been viewed as young populations with a very small and insignificant older component. The minority elderly have also been presented as a small population of the general aged population and thus not demanding great attention. However, recently note has been taken that the minority elderly is a significantly growing component of the aged population and that their situation is particularly precarious and at risk.[3] This type of attention reflects anticipatory concern for the increasing cost of caring for this population. What is overlooked is the fact that the minority elderly are essentially survivors and bring tremendous personal and social resources into old age. This has initiated a small but important search – how the minority elderly have survived and how they can serve as a model for old age for the general population. The preventive approach serves as an excellent framework to analyze the experiences and research of the minority elderly, and to identify professional and programatic interventions that strengthen and enhance such resources in anticipation of predictable and unpredictable situations in old age.

The Minority Experiences of the Elderly

The minority elderly of today are survivors of a most peculiar American history. This minority set of elders share very similar

roots. Most are only one or two generations removed from slavery, conquest, immigration, or forced labor. Their roots are imbedded in a period of history when their ethnicity and race determined the status, roles, and resources that they would have in their lifetime. Their lives were initiated and developed in times of overt discrimination and segregation. The minority elderly of today are the pre-civil rights generation! Because of their color, culture, or language they were to share the experience of being minorities.

Growing up and living as a minority person is not easy. It was much more difficult to do so in pre-civil rights times. This was the period when the major institutions were openly segregated. Of critical significance was the segregation of the educational system which not only generated separate systems but also allocated resources discriminantly. Other critical areas of discrimination included housing, employment, commercial ventures, recreational areas, and even the military. In addition to such differential treatment was the openness of negative racial attitudes toward minority populations. Such attitudes at times manifested themselves in violent behavior toward these minority persons. All of this is to point out that the minority person reaching old age today, has lived through a most difficult period of American social history when, because of racial, cultural or ethnic background, the minority person faced tremendous social, economic, and political obstacles.[4]

The outcome of such an experience is not surprising. The minority elderly today are among the poorest population in the country and possess a most limited reservoir of economic, political, and educational resources. Their housing reflects the history of segregation and economic limitation. Their educational attainment is among the lowest. Their income reflects their work history and their health tells the story of blue collar and manual labor. In other words, the minority persons of today entered old age with very negative consequences of having lived through the pre-civil rights era.

However, not all of the consequences of the pre-civil rights era have turned out to be detrimental. Some have been converted into strengths. As minority persons in the pre-civil rights era, this generation learned to survive with very limited resources. The harsh treatment and constant struggle for survival in the general community forced minorities to develop special personal inner strength, resourceful familial ties, helping communities' networks, and key social and formal institutions which helped them survive.[5]

These strengths and resources assisted them to survive the pre-civil rights era as minority persons. They may very well help them face old age in the post reform era, and especially during the era of the new federalism. These resources may well serve to promote their well being in old age, to prepare for anticipated critical events, and to avoid problematical predicaments of aging.

Resources for Living

That the minority elderly entered old age with the scars of the pre-civil rights era is well established. What is not sufficiently explored are those aspects of their lives that are rich resources for living. These resources were very critical in the survival of this minority generation. As they enter old age these resources can now be looked upon as foundations for building and expanding the ability of this generation to face aging successfully. Knowing the strengths of this generation can also help the professional identify tried and trusted resources that are available to the minority elderly. It is also important to note that these resources are very much mediating structures which were crucial in times of crises but also were critical in the day-to-day lives of minority persons. These resources provided the support and guidance to anticipate and confront the challenges of life.

Ethnic Self-Understanding

It was as an individual that the minority person went forth and confronted life in the pre-civil rights era. The reminder of his or her status as a minority person was constant. It also was a position that was unavoidable and inescapable. To survive successfully the individual had to come to terms with himself or herself and emerge with a self understanding with which he or she could live. For the minority person self-image and self-understanding are intimately related to *ethnic* self-understanding. This refers to the crucial role that ethnicity plays in the development of the person's self-understanding.[6] There are those who suggest that since minority group persons held membership in ethnic groups that held lower status that their self-understanding would likewise be negative. Such a perspective would include that the minority individual

would have an inferiority complex and possess tremendous inner personal weakness. However, this paper argues the opposite position: that ethnic self-understanding involves a realistic understanding of the individual's group membership and the social status of that particular group. The individual knows who he or she is and the role that society has imposed on his or her ethnic group.[7] It is precisely this recognition that helps the individual comprehend his or her peculiar situation and interpret his or her experiences in the broader society. This insight into oneself and to society becomes a resource for self-respect, survival, and well being. Ethnic self-identity becomes a resource for living. This paper suggests that the minority elderly of today have emerged from the pre-civil rights era with a very clear understanding of who they are as ethnic persons and as a minority population, and that this self-understanding can be a rich resource for promoting healthy attitudes toward self and especially toward families and communities.

Inner Personal Resources

At another level it is also helpful to note that to survive the pre-civil rights era as a minority required a great amount of inner strength and determination. When all the obstacles presented to the minority person are analyzed, it is a wonder that these persons survived; it is more so to realize that they overcame hardships to live out life to its full continuum.[8] For example, despite limited resources, these persons achieved very basic educational skills; in spite of limited education these minority persons entered the labor market. In spite of employment discrimination these persons supported families and bought homes. In defiance of all such obstacles this minority generation entered old age. Such life histories indicate that these persons possessed internal resources that helped them to keep going. They must have had a tremendous sense of self-respect and self-worth. They must have possessed a great ability to maneuver in and around racism and discrimination not only merely to survive, but also to acquire sufficient means of providing for their families and communities. This generation of minorities must have really cared for their families and communities to suffer and sacrifice for their survival. It is this level of inner resourcefulness that is unrecognized, unexplored and, certainly underutilized in working with the minority elderly.

Familial Resources

The role of the family within the minority experience is often misunderstood. For some it appears to be a failure and serves only as a block toward full assimilation. This paper suggests that, on the contrary, the minority family played a key role during pre-civil rights in the survival of individual minority persons and cultural groups in this country. It was the family that provided the initial preparation and guidance for the young minority person as he or she took the first steps into pre-civil rights America. The family provided the basic introduction to life and the sense of self-worth and respect. It was the family that provided the initial care and warmth that the minority person needed. The family was the one sure source of support and assistance at times of crises and in the everyday needs of life. It is no wonder then, that for the minority person the family played a crucial role in survival and probably became the most significant social group in their lives. The family was a resource for living.[9]

Informal Resources

To survive, the individual minority person relied upon himself or herself and the family; but beyond the family was another social system that became like a second family: friends and neighbors. This social system was bound not by blood or monies, but through sharing, caring, and helping each other. When the family was not around or not able to assist, friends and neighbors served as a support system. They provided emotional support, advice, presence, services, and even direct aid with no expectation of payment. In some communities such relatives were formalized as the *compadrazco* system among Hispanics. Others refer to the kith network. All of these served as trusted and reliable sources for living.[10]

Community Resources

Beyond the family and the informal network of friends and neighbors a more formalized network of social organizations served as a resource for the minority persons. These include social clubs and civil minority organizations as well as religious institutions.

These kinds of organizations tended to be formally structured with distinct memberships and purposes. However, it was clear that they were predominantly minority in membership and served as resources to that particular community.[11] They provided not only their stated purpose, but also provided avenues for minorities to develop leadership, community events and celebrations, as well as serving as a means for articularing their perspective. Such formal organizations served as important resources to the minority population in their survival of the pre-civil rights era. In fact, it was through one of these institutions (the Black church) that the civil rights movement became a reality.

Sense of Peoplehood

At a much different level, minority persons, especially within their own particular group, have developed a sense of peoplehood. Through the recognition of shared language, culture, racial characteristics, and historical experiences, minorities have developed a shared sense of ethnicity within their groups. The sense of similarity and of sharing provides resources untapped for mutual aid and self help. It helped many survive the pre-civil rights era and may well assist them in old age.

In summary, the experiences of minorities during the pre-civil rights era have resulted in severe socioeconomic hardships for the minority generation now in old age. Today they face great economic, health, housing, and other social problems with relatively no economic resources. As their children move from or continue in poverty, many of these minority older persons are at risk with their well being and very life being threatened. As they face these problems they increasingly become more dependent on the formal service network for financial and concrete assistance.[12] However, the above discussion also briefly outlined various levels of resources that have assisted this older generation to overcome the obstacles of the pre-civil rights period. These included personal inner strength, the family, the social support network, community institutions, as well as a strong sense of peoplehood and ethnicity; such resources served as crucial tools in facing the daily struggle of life, stressful events, and a hostile environment. Such resources also were key to promoting the sense of worth, caring and well being for minority persons. This paper suggests that such are the resources for a preventive approach in old age.

Prevention Among the Minority Elderly

The task of a preventive approach is essentially to prevent or minimize problematical situations and to promote well being.[13] To speak of a social work preventive approach usually refers to an intentional interventive program or effort by professionals for the purpose of preventing or minimizing social dysfunction characterized by maladjusted behavior, relationships, and resources accessing, as well as creating a more responsive environment. The preventive approach also includes the professional promotion of well being. However, it is very important for professionals to recognize from the beginning that the minority elderly, their families, and their communities are already engaged in natural preventive strategies themselves. Such is how they have survived and kept their mental health. The personal and social systems of the minority elderly are already involved in preventing and minimizing misery as well as in promoting their well being. At the root of this point is the notion that preventive strategies are essentially natural and normal strategies in healthy individuals and groups.

The implication of the above perspective is that whatever preventive intervention is designed by the professional must be built upon the natural preventive system already in place and must be compatible with such a system. Such an approach compels the professional to identify the various elements and resources that comprise the preventive system in place and to explore strategies for strengthening these existing resources. The preventive approach also involves the utilization of these resources in new and creative ways, as well as developing totally new resources for the elderly.

In more specific terms the task of a preventive approach is to utilize natural and professional resources in helping the minority elderly deal with the daily problems of living, cope with stressful life events and transitions, overcome environmental barriers, and achieve a satisfying level of well being. Many of these problem-generating situations are predictable for older persons, especially minorities. However, there are always unanticipated crises and problems that arise for which the individual and his or her family must be prepared. As minority persons who probably reflect differences in race, ethnicity, and language, environmental barriers related to racism, language, and culture present real problems for the elderly and thus come within the purview of preventive strategy. The ultimate goal of promoting well being likewise plays an

essential part in a preventive/promotion strategy. This involves the incorporation of a healthy and positive sense of individual worth, purpose, and identity.

In summary, the preventive approach is directed toward strengthening and utilizing the capacities of older minority persons to meet the anticipated and unanticipated challenges of life successfully and to move toward a satisfying sense of well being.

Prevention in Anticipated Processes

The minority elderly can anticipate certain events and processes in old age that are essentially functions of old age. They can also anticipate other experiences that are peculiarly in the realm of the minority. Among those anticipated processes that are a function of old age are those that are shared by most older persons. These include experiences and events such as: (1) *retirement* which incorporates several dynamics such as the reduction of income, changes in public roles (from employed to retired), and the increase of leisure time; (2) *physiological decline* which reflects the aging of the human body and changes in physical functioning; (3) *psychological adjustments* which include attitudes and mental abilities; and (4) changes in *social participation* and social networks. These are aspects of living in which older persons, regardless of ethnicity, can anticipate problematical situations. The task of a preventive strategy is to prepare and assist the minority elderly in anticipating, planning for, and successfully maneuvering through these challenging processes of older life. The goals are to facilitate a successful adjustment to old age and to avoid failures and pathological results.

In developing preventive strategies for these types of anticipatory life situations and processes, it is important to recall the levels of resources available to and trusted by the minority elderly. These levels are essentially: (1) individual/personal, (2) familial, (3) informal networks, and (4) community. It is also important to recall that although these problematical areas have been separated for analytical purposes, they are intimately interwoven in real life. Likewise the levels of resources have been artificially categorized when in reality they are one complex and dynamic totality of interacting elements. All this is to say that preventive strategies must likewise be holistic and sensitive to the many aspects of the

person's life and the interrelatedness of the resource systems. In other words, prevention is holistic, integrative, and sensitive.

Examples of preventive strategies that can be developed for the minority elderly as they face the anticipated processes of old age are varied. Some are not unique to the minority. However these strategies must be developed with a sensitivity to historical minority experiences, resource limitations, and cultural-linguistic variations. For example, preretirement programs that can be excellent educational and planning activities for persons anticipating retirement are excellent preventive programs. However, they tend to be less available for blue collar workers, the unskilled, domestics, and farm laborers. Because so many minorities are employed in such levels, preretirement programs are not available to them. Therefore, the development of preretirement programs specially geared for the minority is a much needed preventive strategy.

Other types of programs that are preventive in nature include educational activities. These range from educational programming within established service systems (for example, in multipurpose senior citizen centers) to programs in colleges that attract elders. However, because of low educational attainment records, minorities are assumed not to be interested or unable to handle "educational" programs. Therefore what is needed is the development of educational programs that take into consideration the limited educational attainment of minorities, that use different languages (Spanish, Navajo, Chinese, etc.), and that emphasize oral and visual techniques. Educational programs are critically needed to inform and train minority adults about the normal problems of aging and the use of resources for their well being.

At another level educational programs are needed to prepare and train the minority family and community to care for the elderly. Relying on the established value systems and active support networks, educational programs could teach minorities what to expect in older persons and skills in caring for them. Where the family and the informal support network is alive and well, preventive measures are essentially educational in nature. Where there is no family or caring network, preventive measures are directed at organizing self-help groups and networks as well as sensitizing the established minority institutional system regarding the needs of older minority persons. When all of the above are not available, the preventive approach is directed toward linking those older minorities living alone with the service network so as to provide for their well being and the early detection of potential problems.

Prevention in Unanticipated Problems

While many of the life processes, stressful events and environmental barriers can be anticipated, nonetheless there are some that cannot be predicted. These include such problematical situations as the sudden loss of a spouse, crime victimization, acute health problems, and chronic illness. Natural and social catastrophies are also unanticipated. In these cases, the preventive approach is directed not so much to avoid these situations but to strengthen the individual's or system to such a degree that he or she will be able to utilize personal strengths, familial support, friends, and community to overcome these unexpected events successfully. Organizing self-help groups and linking persons to community networks is another strategy that anticipates the unpredictable and facilitates assistance to these vulnerable persons in times of crisis. The key is to prepare the community resources and linking people so that the network will be in place and ready to take action at times of critical need.

Minority Problems of the Elderly

There are problems that the minority elderly face that tend to be especially pertinent to persons belonging to minority populations. These are problems or situations that are confronted primarily because of the older person's minority ethnic or racial background. For example, language barriers are particularly problematical for Hispanics, Asians, and Indian Americans. This environmental barrier is confronted not only in the daily interactions with the broader community (commercial, media, government, etc.) but especially with the social service network upon which minorities have become increasingly dependent for financial and concrete services. The preventive approach would generate language classes for minority persons so that they can negotiate through this barrier, and language lessons for the service providers to eliminate the language barrier altogether.

Another area that is especially different for older minorities involves the cultural barriers that exist between minority groups and the dominant population. These differences become critical in the design and administration of social services, including nutrition programs. A preventive approach would not try to change the

minority elder culturally; its aim would be to sensitize and educate the service providers to cultural differences. Included in this type of environmentally targeted strategy is the concern for racism and race relations. The minority elderly are products of the pre-civil rights era when racism was openly practiced. It is difficult to forget such a life long and painful experience. Therefore it is not surprising that they are especially sensitive to racial remarks and other practices – reflecting racial differences. At times it is difficult for them to participate in racially mixed activities. Thus, the staff, especially white persons, need to be made aware and prepared to overcome racial issues. The task is to prevent problems due to cultural and racial differences.

Barriers to Preventive Programs

Although prevention concepts have received wide attention and recently increasing attention in social work, it is a strategy that still confronts resistance. Its application to the field of aging requires overcoming several blocks. For example, aging myths themselves provide a barrier to the application of preventive strategies. Because aging is a natural and unavoidable process, its related life conditions and processes are likewise held to be natural and unavoidable. For example, bad health, social isolation, and senility are assumed to be expected aspects of aging. Research and practice have shown that all of these can be prevented or minimized through preventive measures.

Another barrier to the application of prevention concepts to the elderly is ageism itself – the idea that older people are already beyond help; that they cannot learn; and that whatever assistance is provided, its value will be for only a short period. In addition, older persons are not viewed as desirable clients with which to work. All of these attitudes block the way for the creative development of preventive strategies that seek to strengthen the capabilities of older persons to enhance their well being.

Another barrier to prevention among the elderly includes the basic philosophy of the social service systems. The medical-pathological model directs our social services. Social work intervention is encouraged only when a problem has been detected. To design programs intended for healthy persons or even for potentially problematical situations is still viewed as being against basic American principles. However, recent programs in aging have moved

toward the preventive and promotional – for example, social security, nutritional programs, and home based services. Nevertheless, the philosophy of nonintervention in healthy situations remains as a fundamental barrier.

Evaluation of Preventive Programs

As Reinherz has well articulated, the methodological problems in evaluating prevention programs are extensive.[14] Prevention is such a new interventive strategy and is so complex that the issues of evaluating the effectiveness of prevention programs is quite challenging. Nevertheless, the need for developing an empirical base remains and indeed must be established if prevention is to develop into a credible and effective strategy.

Evaluating preventive programs among the minority elderly is an especially difficult and needed endeavor. What knowledge base exists regarding the minority elderly tends to focus on sociocultural understanding, socioeconomic problems, and service utilization. Minority aging is just now developing into an empirically-based field of knowledge. What is lacking, however, is evaluative research on successful intervention, especially preventive programs.

In conducting evaluative research on preventive programs among minority elders, several special issues are involved in addition to those that apply to prevention in general. These include language and cultural barriers that may hinder evaluators of different ethnic backgrounds. These differences can affect access, instrument design, and interpretation. Research into natural ongoing self-help systems also can result in contamination and destabilization. Evaluation requiring self-reporting can also be problematical for low literacy populations. However, the most problematical issue in evaluating prevention programs among the minority elderly is probably the lack of such programs to evaluate.

Social Work Education and Prevention

Social work education is in a very crucial position of opportunity to incorporate preventive content and orientations in its curriculum. Social work can easily incorporate the preventive approach to its already established rehabilitative role. The out-

come would be a continuum of professional service that encompasses prevention/promotion, rehabilitation, and long term care. Our task is to complete the continuum of professional services that aims at assisting individuals, families, and communities to prevent problematical situations, to care for self in time of need as far as their skills and resources permit, and to care for those who cannot care for themselves. Overriding this continuum is the ultimate goal of maximizing well being given the context.

The multidisciplinary foundations of the social work curriculum offer an excellent framework for incorporating prevention strategies. The basic structure of social work educational programs provides excellent avenues for the inclusion of preventive content. For example, the Human Behavior and Social Environment component is an excellent area in which a more positive understanding of aging could be demonstrated. Likewise, a basic understanding of the minority experience should be included. The thrust of preventive content would be to illustrate how individuals, families, and communities engaged actively in preventing problems and promoting their well being. Such content can serve as the much needed base for preventive intervention.

Direct practice content can also include more examples of cross-cultural and intergenerational practice. It is rare when social work direct practice content pays attention to the impact of the cultural and age element in case work. Direct practice also needs to move beyond rehabilitation and include knowledge and skills related to helping people prevent potential problems.

Indirect practice, which includes administration, planning, and community organization, can incorporate skills in organizing elderly self-help groups, and advocacy groups of older persons. This curriculum area also can incorporate concern for the design and administration of areas such as language, culture, and racism that serve as environmental barriers to minority older persons.

The policy area is critical for prevention strategies. This curriculum area can include more critical analyses of national policy and services, especially those that undermine independent living, family networks, and community based services. Also, national policies and programs tend to overlook the special needs of minority groups and to neglect their special situations.

Field placement also is an area that can include more opportunities for students to experience preventive approaches. Developing placements only in large well-established service agencies many times prevents students from experimenting with creative

strategies of prevention. Field placements developed in neighborhoods and communities with minority older persons need to be encouraged, especially with community organizations and self-help groups. Special attention could be given to assuring that students will be engaged in preventive as well as rehabilitative activities.

In summary, the social work curriculum covers the critical areas of knowledge and intervention – from the individual to the community, from the client to national policy. All levels of need and all levels of intervention are legitimate spheres of social work practice. Our task is to move beyond the rehabilitative and to include the preventive.

Conclusion

The minority elderly are indeed a special population. They survived a very difficult period of history probably because of resources available to them within themselves, their families, and communities. As they now enter old age their life is complicated by their poverty and ethnicity. Yet, it has been suggested that the same resources available to them in prior stages of their lives can be also utilized in their old age. These resources are preventive in nature and are part of the natural community life systems of minorities. The task of social work education is to incorporate this knowledge and experience within a preventive framework as part of social work curriculum. Our curriculum is holistic and multidisciplinary – ideal foundations for a preventive approach.

Notes

1. Sharon M. Fujii, "Minority Group Elderly: Demographic Characteristics and Implications for Public Policy" in *An Annual Review of Gerontology and Geriatrics*, ed. Carl Eisdorfer, et al. (New York: Springer Publishing Company, 1980.)

2. The term "minority aging" is used very differently from Jacquelyne J. Jackson who defines Hispanics as white and includes white females in her discussion and observation about minority aging in *Minority Aging* (Belmont, Calif.: Belmont Publishing Company, 1980).

3. U. S. House of Representatives, Subcommittee on Human Services of the Select Committee on Aging, *Future Directions for Aging Policy: A Human Service Model*. (Washington, D.C.: U. S. Government Printing Office, 1980).

4. Joan W. Moore, "Mexican Americans", *The Gerontologist*, Vol. 2 No. 1 (1971) pp. 30-35.

5. Fernando Torres Gil, "Age, Health and Culture" in *Hispanic Families*, ed. Miguel Montiel (Washington, D. C.: National Coalition of Hispanic Mental Health and Human Services Organizations, 1978).

6. David Maldonado, "Ethnic Self-Identity and Self-Understanding," *Social Casework*, Vol. 56 (December 1975), pp. 618-22.

7. Donald E. Gelfand, *Aging: The Ethnic Factor* (Boston: Little, Brown and Company, 1982).

8. Joan W. Moore, "Situational Factors Affecting Minority Aging," *The Gerontologist*, Spring, 1971, pp. 88-93.

9. David Maldonado, "Aging in the Chicano Context: in *Ethnicity and Aging*, ed. Donald Gelfand. (New York: Springer Publishing Co., 1979), pp. 175-83.

10. Ramon Valle and William Vega, *Hispanic Natural Support Systems*, (North Highlands, Calif.: State of California, 1980).

11. Jose B. Cuellar, "El Senior Citizens Club: The Older Mexican American in the Voluntary Association" in *Life's Career: Aging Cultural Variations on Growing Old*, ed. B. G. Myerhoff and A. Simic. (Beverly Hills, Calif.: Sage Publications, 1978).

12. David Maldonado, "The Chicano Aged", *Social Work* (May 1975), pp. 213-16.

13. Carel Germain, "Teaching Primary Prevention in Social Work: An Ecological Perspective," *Journal of Education for Social Work*, Vol. 18 No. 1 (Winter 1982) pp. 20-28.

14. Helen Reinherz, "Evaluating Programs of Primary Prevention: How Can We Know if They Make A Difference?" *Primary Prevention in Mental Health* (New York Council on Social Work Education, 1981), pp. 54-63.

7

Themes and Models in Primary Prevention with Minority Populations

Samuel O. Miller

The idea of identifying, developing, implementing, and evaluating systematic strategies aimed at the prevention of social or mental disorders in ethnic minority individuals, families, or communities has an uncanny appeal. The prospects are exciting in numerous respects, and the implications no less crucial and far-reaching.

From a sociopolitical perspective, this effort would herald society's recognition and conscious acceptance of its responsibility for eliminating or ameliorating factors associated with disorders endemic to the most vulnerable segment of its population. In the process, society would naturally and creatively alter its institutions, rearrange its priorities, and more equitably redistribute its resources in an effort designed to "get children (and other populations at risk) through our health, family, school (and other critical institutions) smelling like a rose"[1]. In effect, our social system, in

an attempt to become truly humane, would take real actions to prevent the development or continuation of problems, while making alternative uses of existing remedial and rehabilitative institutions.[2]

The appeal is practical in that it would give priority to health and coping – the most positive aspects and the identified strengths of ethnic minority individuals and communities. Prevention with ethnic minority populations presupposes efforts to build adaptive strengths, rather than contain already manifest deficits and actions, and to equip this population with resources for coping, rather than dealing (however skillfully) with problems already germinated.[3] To accomplish these objectives appropriately would require a simultaneous profound and studied orientation to the latent and manifest potential of ethnic minority communities, a vital recognition of the implications of their sociocultural values, and greater sensitivity to the ethnic distinctive dimensions of social work practice. The implications for shifts in the current assumptions, practices, and policies underlying existing treatment and rehabilitative services are equally obvious.

It is critical to note early in this discussion that while prevention is concerned with total populations, with reducing the number of new cases, and with reducing stress at its source, prevention is not offered as a rationale or support for abandoning society's or social work's concern with and responsibility for ethnic minority individuals and families with already defined emotional difficulties. Indeed, many of the insights, approaches, and practices informing the models and programs of prevention emerge from the wisdom developed in providing clinical and social services. Similarly, since it is uncertain how much time will elapse until prevention programs are a viable and continuing reality and since there will continue to be casualities, it would appear professionally irresponsible and inappropriate to consider dismantling current treatment and rehabilitative programs and activities.

Thirdly, the appeal is economical. The wisdom inherent in the old adage that "an ounce of prevention is worth a pound of cure" is still true today. It is even more true regarding the population of ethnic minorities, which is the concern of this monograph. The questionable effectiveness and efficiency of established social and mental health services for ethnic minority individuals and communities have been repeatedly documented.[4] Equally identified has been the resulting underutilization of services by this

group despite the historical commitments of the respective disciplines and their vociferously acknowledged competence for promoting adequate social functioning.[5] Thus despite periodic changes in concern, methodology, and contexts of clinical treatment, the expansion of knowledge capable of informing current practice and service delivery and the best of intention on the part of individual and groups of clinical practitioners, the social, physical, and mental health of ethnic and racial minority groups is still in grave jeopardy and the treatment of illnesses that occur in these populations woefully inadequate and frequently inappropriate. In light of this fact, the potential benefits – in human, physical, and economic terms – of a qualitatively different, yet viable, approach represented by the preventive perspective merits every professional consideration. As if these economic advantages were not enough, as noted by Buell "the good ends of preventive programs – health, housing, family life, reactions, etc. – carry their own social justifications."[6]

The last implication to be noted here is by no means the least in import or substance. However, adopting a preventive-oriented stance would also have serious professional implications on two critical fronts. On the one hand the depth of social and emotional ills and needs affecting ethnic minority populations is extensive and thus should command the unrestricted attention of the mental health professions. This concentrated focus, emphasizing a preventive thrust, offers a unique and unprecedented opportunity to increase our knowledge about our skills in prevention. It would enable us to clarify the vagueness of the concept,[7] to differentiate a conceptualization specifically applicable to social problems and social welfare, from existing public health and related conceptions, and to reduce the confusion engendered by applying the adjectives – primary, secondary and tertiary to prevention – while simultaneously operating to maximize the best interests of ethnic minority communities.

In the second place, social work's conscious and deliberate commitment to prevention would reestablish its special and historical competence in the realm of preventive intervention. As noted by Northen prevention through social legislation, social action, and community planning and organization has been with the profession since its early days.[8] Despite this historical involvement, the provision of viable preventive services and the concomitant recognition and legitimation of this professional function remain an illusive professional task.

Forces Against Preventive Practice

Despite the compelling nature of the above mentioned rationales, the forces against the establishment of a truly preventive thrust are enormous and active, not the least of which is the current social/political climate. At a time when we should be eliminating environmental factors associated with social and emotional problems, promoting the growth and development of our most vulnerable citizens, and protecting the rich heritage of ethnic minority populations, actions are repeatedly taken that create greater stress and burdens and that systematically destroy ethnic resources painstakenly developed through the centuries. At a time when important federal prevention programs have been enacted, when the Office of Prevention of the National Institute of Mental Health has begun to make its impact felt nationally, and when critical progress in knowledge has emerged from such activities as the Annual Conference on Prevention, a convoluted retrenchment, not only in funds but also in philosophical and professional commitments to the concept of preventive programming, has taken its toll on future developments. The ultimate determination of this controversy will take place in the political realm; social workers have much to contribute in their personal/political roles.

Two additional deficits, more amenable to professional efforts, plague the process of developing a viable preventive approach in social work, as in other mental health disciplines. They include the state of the art or the knowledge base of preventive practice in general, and, more specifically, prevention as applied to practice with ethnic minority populations; and secondly, the systematic preparation (or the lack thereof) of professionals to competently engage in preventive practice. This volume is a deliberate attempt to fill the professional gap – both in developing knowledge to guide preventive efforts with minority populations and to contribute to the preparation of current and future practitioners.

Themes in Prevention Practice with Ethnic Minorities

Theoretical debates flourish regarding the concept of prevention. They range from the theoretical and practical distinctions

between primary, secondary, and tertiary prevention to whether mental health practitioners do not have a responsibility to emphasize care of previously identified patients, the major activity for which they are trained. One of the most insidious conclusions stemming from the ongoing debate suggests that practitioners should resist engaging in preventive strategies, since the causes of social and mental disorders have not been isolated. The proponents of this position overlook several issues. Among these is the fact that the original public health practitioners had not succeeded in isolating the single cause of smallpox when they implemented actions that heralded the first small step in the process now accepted as prevention. Similarly, they appear to minimize the knowledge emanating from the current ecological perspective which postulates the absence of single causal agents in most disease syndromes.

Another negative result has been the failure to organize and effectively utilize the existing knowledge about prevention systematically, much of which is increasingly being substantiated through systematic research. The information and theoretical conceptualizations in this monograph make a singular contribution to the expanding knowledge base. While they, and previously articulated concepts and ideas, are formed by the values of the mental health professions, rooted in the behavioral and social sciences, and employ certain established therapeutic strategies, they reflect a paradigm that is qualitatively different from the past dominant thrust of the mental health disciplines. The qualitative difference is even more acute when the knowledge is adapted to emphasize distinctive themes and approaches salient to the interests of minority populations.

In developing this monograph, the authors and their respective fields of practice were selected with the specific aim of expanding the knowledge regarding preventive practice with ethnic minority groups and communities. An outline and series of questions were provided to guide the authors' explication of their subjects. However, given their individual styles and creativity, as well as the level of development and the critical issues defining each field, there was no expectation that strict comparability between chapters would be forthcoming. Yet, there are enormous areas of agreement among the authors on various dimensions that distinguish prevention theory and practice and numerous original ideas and emerging conceptualization.

The authors do not deny the existence or importance of

biological and physical factors as causative, yet they are unanimous regarding the salience of environmental factors, particularly those associated with institutional racism and discrimination, and their concomitant effects on people of color, as initiative, if not linearly causal, of a large portion of the problems residents in ethnic minority communities experience. Inherent in this orientation is the fact that preventive efforts are most logically directed at the causative agents and the social, impinging environment rather than primarily or automatically at the host – the ethnic minority individuals, groups, or communities. Depending on the predisposition of the practitioner, theoretician, or evaluator, this orientation represents either an opportunity or a hindrance. Since the proposition suggests multiple, systemic causal entities, different effects and various time phases in the genesis of problems, those who wish to interrupt the progression of problems will recognize repeated opportunities for intervention. On the other hand, those with less credence in this perspective will be frustrated with the absence of strict cause-effect relationships and will complain about and be hampered by not knowing where or how to begin intervention.

Brown states that "the task remains, however, to conceptualize and implement preventive practice properly as the first level of a service continuum. . . . "[9] With this comment she echoes the conviction of the remaining authors that the most desirable time to implement preventive intervention is as early as possible and much before problems develop. In the prevention literature, time is a critical dimension, almost single-handedly accounting for the theoretical and practical distinction between primary prevention, treatment (secondary prevention), and rehabilitation (tertiary prevention). The insidious effects of many problems confronting ethnic minority individuals, frequently and simply because of their very status as members of minority groups, begin to take their toll early in their lives. If anything, the effects expand and multiply with time, except in those fortunate circumstances when protective elements develop within the nurturing environment, or the family. Consequently, a profession interested in fostering the prevention of social and psychological problems of ethnic minority citizens must naturally give considerable attention to the time dimension in planning and intervening.

It is no surprise that the authors pose different social units as prevention targets. This variety is a logical outgrowth of the field of practice they represent and is emphasized in their elabora-

tion. Nevertheless, there is a conversion of opinions on the ethnic minority family as the principal target or unit of attention. Further, there is tacit agreement that such a focus benefits both the individual family members, the extended minority community, and, ultimately, society. The stance also receives support from practical, epidemiological, and historical evidence. Similarly, societal and professional interest may well be enhanced, given the identifiability, manageability, and boundaries of the family unit that makes it a tangible target and given the historical importance attributed to the family in both ethnic minority communities and society at large.

Bloom makes a distinction between active and passive interventive strategies, dependent on the effort expanded by the potential beneficiary of these activities.[10] The authors are unanimous in opting for what, according to the Bloom classification, are considered passive strategies. This is no cop-out. Rather, it is a clear recognition of the complexity of the problems, the efforts which ethnic minority communities have and continue to expend in their behalf, and more significantly that the elimination of racism and discrimination and preventing the problems they engender in and for minority communities are tasks that only society can accomplish. The numerous positive changes and benefits for the entire society resulting from recent litigation, court decisions, and social policy – all "passive" preventive strategies – provide ample support for this position. Although some may raise concern regarding the coercive nature of these strategies, these questions pale in comparison to the tragedy and destructive results when the social cancer of institutional racism continues to exist unchecked.

Although cognizant of the enormous difficulties – theoretical, practical, and economical – in mounting a viable preventive effort on behalf of ethnic minority individuals and communities, the authors express broad enthusiasm for this objective. Their enthusiasm is not unfounded. Rather, they cite a variety of existing indigenous resources that provide a solid foundation on which to build such an effort. The resources mentioned include, on the one hand, those individual attributes of personal strength, capacity to overcome obstacles, sense of respect and self-worth, the commitment to education and to work, and the positive appreciation of ethnic pride; and on the other hand, those community variables of resourceful family ties and extended relationships, key social and formal institutions, and established helping networks. Their views and documentation provide further support to the growing recog-

nition of a more adaptive psychology, different behavioral expectations and a salutary approach to role relationships within ethnic communities, all tangible benefits emerging from the civil rights struggle of the 1960s. One obvious implication of these changes and benefits is the current readiness of ethnic minority communities to move beyond interests in and concerns with simple survival to institutionalizing efforts to promote their health, protect vital resources, and prevent those preventable diseases and problems. Existing models of prevention provide some important and instrumental directions for the future.

Prevention Models: Their Implications For Ethnic Minorities

A careful review of the literature on prevention revealed six approaches or models. Further reflection suggested that these are in fact different emphases on one or another factor and do not imply separate or inherent strategies.[12] Three models – Disease Prevention, Health Promotion and Health Protection – allude to the goals and objectives of the interventions in action terms, while the remaining three focusing on the Developmental Life Cycle, Populations at Risk, and the Social Ecology allude to the object or recipient of the preventive efforts. In the discussion to follow, the six models are defined. In each case the implications of these approaches to ethnic minority communities will be presented, through highlighting a representative problem of import to ethnic minority individuals and communities which appear amenable to the respective approach.

GOAL-ORIENTED APPROACHES

1. Disease Prevention embodies services and procedures designed to minimize the incidence or reduce the rate at which new cases of a specific disease or disorder develops.[13] The strategies developed to prevent the disease are usually derived from an analysis of the risk factors related to the respective disorder.

A health problem of increasing concern to ethnic minority populations is sickle cell anemia, a disease which primarily affects Blacks and Puerto Ricans. The risk factors associated with this

disease – miscarriages, chronic weakness, physical and emotional disability, and ultimately death – are fairly well-documented. Less-documented but equally significant to a comprehensive prevention program are the need and ability to distinguish between the trait and the disease, the limited knowledge of the disease and its implications within or by the populations at risk, the distinctive ways in which people handle and are affected by the disease, and the psychosocial effects of sickle cell anemia, including the impact of labeling and stigmatization.

Effective prevention through disease prevention – lowering the rate at which new cases develop – must begin with the development of a carefully derived program for detecting carriers and combining reliable laboratory methods with skillful and adequate emotional and physical preparation for screening. The immediate objective would be the identification of individuals who, while not themselves manifesting the genetic disorder, do carry single abnormal genes. The second phase would involve appropriate follow-up care and genetic counseling, since it is known that when the single abnormal gene combines with similar genes in a spouse, the result is the sickle cell disease, and the implications are physically and emotionally serious.

In coping with the established physical disease of sickle cell anemia, medicine has taken primary and appropriate responsibility. In prevention, however, where the psychosocial factors loom large and may seriously impact on whether individuals ever come to the attention of medical professionals, social workers have a unique responsibility and critical contributions to make.

2. Health Promotion encompasses a variety of practices that have a positive effect on health in general, and may, in fact, prevent a variety of forms of disordered behavior.[14] These practices include information dissemination and education that encourage good health practices on the part of the individual. They may also involve crisis intervention services, provision of social supports in times of stress, and activities designed to improve the socioeconomic and physical environments, thus enhancing their positive effect on the health of individuals and communities.

Drug dependence has been documented as a significant cause of death among Puerto Ricans, Chinese Americans, and urban

Blacks.[15] Above and beyond the tragic ultimate demise of long-term abusers, the social and economic costs of this syndrome (individually and collectively) are immense and obvious. Despite the conflicting ideas regarding the motivation for abusing such substances as drugs and alcohol, there appears to be agreement that people use them because they are preferred modes of behavior at a given moment, usually at a point of stress. Consequently, as Cohen suggests, the "underlying preventive strategy is to present more desirable alternative involvements – activities, life styles, and satisfactions – which are more rewarding than drug experiences and incompatible with dependence on chemicals."[16]

Educational and information-disseminating programs on the consequences of substance abuse have implications for promoting good health habits in ethnic minority populations, especially when provided in a way that is commensurate with ethnic life styles and the identification of realistic and appreciable personal options. Similarly, efforts to reduce the serious and increasingly high rate of unemployment among ethnic minority adolescents, increase their options for the future and develop problem-solving skills and promote competence in realistic life skills would have a positive effect on their health in general and may very well prevent the abuse of drugs and alcohol.

3. Health Protection embodies an approach to fostering general health through the regulation and control of activities related to environmental factors affecting health and interventions designed to loosen up social strictures, create social changes in society with the goal of making it more humane or responsive, or enhance its capacity and motivation to affirm the qualities of people that are uniquely human.[17]

The prevalence of child abuse, the deliberate or nonaccidental affliction of physical injury or emotional or mental damage to a child by another person usually related by blood or association in ethnic minority communities has been repeatedly documented. Enormous secrecy frequently surround these incidents. However, when publicized or known to the legal authorities or social service personnel, several characteristic features are identified. They include social isolation of the adult unit, alienation from the supportive network of the community – both personal and institutional – unemployment, numerous physical problems, poverty,

frequent moves, limited education, substandard housing, and the extended scapegoating of the one child who eventually becomes the abused. These features are important to primary prevention for a number of reasons. They represent the various points at which preventive action may be introduced to break a vicious and far reaching cycle. Efforts to regulate the reporting of suspected abuse is one step in the direction of protecting the health of vulnerable citizens, although greater success in preventing abuse would be forthcoming if the regulation and creative social change came early in the cycle of this syndrome.

A critical action reflecting this model of prevention includes the protection and fostering of the positive forces in ethnic minority communities, one of which is the supportive network which leaps to pick up the slack or substitute social resources when the primary caregiver is absent or deficient. The Foster Grandparent Program, reported on by Ranes and Chiapetta is an ideal example of this model.[18] On the one hand, the program was influential in improving parenting skills, facilitating changes in various areas of family life, and abrogating the need for litigation by Child Protective Service, ostensibly preventing a variety of future problems. Simultaneously, the program emphasized the value of the ethnic minority aged participants, of their capabilities, wisdom and expertise – all invaluable indigenous community resources – and in turn gave to many a new lease on life and a tangible reason for being. The impact of these factors in preventing problems among the aged has been fully discussed by Maldonado.[19]

Citizen involvement and participation, self-help groups, and community action are examples of this model in operation. Related techniques, such as legislative lobbying, litigation, client advocacy, and leadership development, all have consequences for protecting the existing health of individual and communities. This model truly makes the assumption that ethnic minority individuals and communities are healthy or have the potential for reflecting healthy behaviors, with the environment or disease producing agents the object of any requisite intervention.

OBJECT-ORIENTED APPROACHES

1. Developmental Life Cycle refers to the various preventive programs organized around facilitating mastery of the ordinary demands related to life transitions or reducing the incidence of negative responses to particular stressful life events.[20]

The choice of a representative transition point or a particularly stressful life event was at once easy and difficult, given the enormous range from which to select. In data recently presented by the Special Populations Subpanels on Mental Issues of the President's Commission on Mental Health the overwhelming repetition of negative indicators led to the unmistakable conclusion that members of minority groups are at enormous risk in all aspects of their social, physical, and mental health.[21]

The birth of a first child, a common life task, permits discussion of a wide range of potential preventive efforts. The ethnic cultural context attaches enormous value to the advent of a new family member. However, counterproductive socioeconomic factors frequently surround this experience with less than optimum features, as in the cases of many teen-aged pregnancies, premature births, multiple children extremely close in ages, and handicapped children. Despite these stress-producing situations, numerous minority families seek to provide for these family members without the benefit of established and available services in mastering the accompanying demands. Yet, there are numerous casualties. Many first parents suffer enormous trauma and insecurity about the appropriateness of their actions and many first (and subsequent) children bear the brunt of such hit-and-miss efforts well into their adulthood. In this respect, the potential benefits are enormous from preventive programs such as family life education, which uses educational approaches to convey to participants a clear, new, or different perspective on the tasks of parenthood. Additional features of a comprehensive program to assist first parents should include genetic counseling, prenatal and para-natal care, parent effectiveness training, problem-solving skills training, and the identification and utilization of self-help groups.

2. Populations at Risk include many preventive programs with involved efforts to reduce vulnerability of a specific group of individuals, who may have an educational, occupational, or environmental problem, but who are not mentally ill or identified as clients.[22]

In a prior publication this author noted that "two major factors, the age distribution of ethnic minority populations and their almost uniform status as urban dwellers, appear to compound their plight and increase their vulnerability to dysfunctioning. For most ethnic groups the number of children and adoles-

cents in the total population approaches one half."[23] Given the number of juveniles in the population, a very high risk of future delinquent careers is present. The risk is even greater with the documented existence of the exorbitantly high unemployment rate of minority adolescents, the limited opportunities available, and the insidious effects of discriminatory practices.

The patterns of delinquency are numerous, from innocuous behaviors such as juvenile pranks to more serious and violent crimes such as rape and robbery. Similarly, the age at which the delinquent behavior begins and the precipitating events differ from individual to individual, and from situation to situation. In view of the numerous factors contributing to the creation of juvenile delinquency, there appears to be no simple or single approach to its prevention. Preventive efforts can be directed at changing the socioeconomic system or by intervening directly with adolescents who seem likely to embark on a delinquent career. The former can be accomplished by expanding the opportunities for gainful and prideful employment, cognizant of the fact that if ethnic minority adolescents are employed in an organization or work in which they have a sense of pride and investment, they are less likely and will have fewer reasons or opportunities to engage in delinquency. Interventions deliberately with the adolescents at risk might include anticipatory guidance, enhancing their self-esteem, provide culturally relevant employment, career and educational counseling, and linking them up with cogent, ethnically sensitive institutions, including their families, to enhance their ethnic pride.

3. The Social Ecological Model refers to the promotion of sound development through fostering sound institutions representing those areas that heavily influence the daily life of the community and its residents, changing social structures and coordinating communication to enhance efficient planning, problem solving, and the avoidance of gaps in services.[24]

This approach acknowledges the fact that human development is profoundly influenced by key institutions, particularly those established, maintained, and underwritten financially by society. They serve as the conduit through which goods, services, rewards, and punishment are distributed and through which society implements its collective decisions and policies. For ethnic

minority populations the consequences of their operations have been uniformed lack of access to the major benefits and opportunities and severe deprivation. Riddled as they are with racism, it is no wonder that the fit between the functions and concerns of these major institutions and the interests and needs of minority individuals and communities does not mesh adequately. To survive, these ethnic minority individuals and communities have had to make numerous adaptations to the institutions or create their own indigenous organizations, such as the ethnic churches and welfare institutions.

One of the most critical societal institutions is the school, whose essential function is to foster personal, social, and mental development for both current and future use. To the extent that it educates students in critical areas, promotes competence, provides problem-solving skills, and creates effective adults, it is the epitome of a preventive-oriented organization. Yet, the dropout rate of ethnic minority students in elementary and secondary schools is extremely high. That this is a major problem is no question. That it is preventable has much to do with the manner in which mental health practitioners, including social workers, use their expertise and actively work to reduce these dropout rates, and the mental and interpersonal catastrophe which school dropout engenders in the individual.

In recent years, enormous success has been reported with the provision of mental health consultation to school personnel. Consultants with substantive knowledge and appreciation of the impact of ethnicity on functioning and development can provide valuable technical assistance and useful knowledge to teachers, administrators, and other personnel. The objective of this preventive approach centers around the identification of factors within the school, the educational policies or program, the administration or actual teaching that can and does discourage ethnic minority students from continuing their education, and that makes dropping out attractive, feasible, or inescapable. The assumption is that those parties responsible for the educational program will utilize this knowledge and the strategies it suggests to institute substantive changes in the social ecology of potential school dropouts.

It has been suggested that knowledge about and skills in prevention strategies are necessary but not sufficient conditions for developing and maintaining a truly viable preventive perspective, particularly for ethnic minority groups, individuals, and communi-

ties. To complete the process, it is necessary for schools of social work to train and educate competent invested professionals systematically. This next section suggests some of the teaching-learning areas requisite for the accomplishment of this objective.

Requisite Teaching-Learning Areas

Prevention is an interdisciplinary and societal responsibility. The problems social workers seek to prevent are complex, intransigent, and frequently personally and psychologically catastrophic. That this is true should lead teachers and learners to be cautious. But caution should not preclude interest in experimentation, systematic knowledge and skill development, and, above all, preparedness to act preventively. When the specific foci is ethnic minority individuals, families, or communities, the requisite preparation is at once more acute and necessary, albeit not routinely acquired. Thus it is incumbent on social work education programs to develop a curriculum or to integrate the existing and developing information, knowledge, and skill that cogently prepares future practitioners for competent performance in the field.

Given the current professional climate, including the commitment to treatment and rehabilitation with which students enter graduate school, providing a clear historical perspective on prevention is imperative. The objective is to enable students to develop a personal and professional conviction regarding the practice of preventive activities. A conviction that is primarily attitudinal is necessary but not sufficient. Rather, it must be abetted by substantive information, and, even more critical, infused with behavioral skills and a sense of how these relate to the prevention of problems confronting ethnic people.

There are numerous overarching propositions that are useful in social work practice with minority prople. Many of these propositions, together or singly, appear to be necessary if not essential in preventive practice. A few of these propositions are mentioned as illustrative of the knowledge base requisite for preventive practice.

Students need to appreciate the existence and substance of the various frames of reference existing in minority communities regarding behavior, normality, deviance, and prevention. While these perspectives are embedded in or influenced by the larger society, the differences between the two are noteworthy and extensive in their impact. The impact of these differing frames of

reference are noted in the varying views of disease and illness, the tolerance and management of symptoms, the coping with illness (including the delay or speed in seeking consultation outside the lay system) and the expectations of minority citizens of the professional encounter. Since prevention focuses on and frequently requires the active involvement of communities, their perspectives on what is preventable and on the resources to be distributed between prevention and other desirable ends will have serious implications on the success of professional preventive activities.

Similarly, it is necessary for developing practitioners to consider that the sustaining and nurturing environments have differing impacts on minority individuals, including their approach to and accomplishment of life tasks. Thus it will be necessary to teach students about the differential impact of racism and discrimination (within and between ethnic minority communities and individuals) on their self-image, their sense of competence, their development of cognitive and behavioral skills, on their coping at critical age levels, particularly in childhood and adolescence. Since the viable practice of prevention assumes identification and recognition of existing strengths and growth producing factors on which to build, and since, unfortunately, much of what is taught about ethnic minorities fails to identify the natural positive forces, an orientation that encourages a realistic appreciation of these items will be absolutely essential in preparing for preventive practice.

One last example of overarching propositions is the impact of historical events on current behavior and functioning. The history of each ethnic group – Blacks as slaves, Native Americans' confinement on reservations, some Hispanic groups as conquered people, and the restrictive manner in which Asian Americans have been permitted to migrate to this country – including their subsequent exclusion from many of the socioeconomic opportunities requisite for their striving and integration into American society continue to exert influence on the residents of these communities. The influence is frequently widespread and observable in behaviors and coping patterns within families and in their perceptions of and reactions to stress. Consequently, faculty will have to impart substantive knowledge on this reality and the range of alternative structures, support systems and processes developed, as well as on the successful achievement of large segments of these populations against seemingly insurmountable odds. Only knowledge and appreciation of these latter will avoid the unwitting destruction of indigenous institutions and support systems in the process of pro-

viding professional intervention.

The development of an ethnic model of prevention may take numerous routes and emphasize various constructs. However, any approach would be deficient without selected emphasis on how ethnic minority individuals experience or cope with the developmental life cycle. On the one hand the knowledge assists in isolating individuals or age groups who may be at risk from those who will or may continue to cope successfully, requiring different, if any, interventive strategies. On the other hand, it assists in identifying points at which problems – preventable or otherwise – may develop and where professional preventive programming may be desirable or effective. If the teaching-learning is to be successful and uniquely cogent, it will have to emphasize the distinctive ethnic nature of individual and community efforts to cope with life tasks. Billingsley has suggested that Black (and obstensibly other ethnic minority) parents must teach their respective children specific survival techniques.[25] This requirement imposes an ethnic imperative which, in turn, influences the perception and implementation of life tasks, about which students will require selective input.

Among other things, students will need to learn about the manner in which prospective ethnic parents prepare for childbirth and parenthood, including such issues as the protective mechanisms utilized to cope with real or imagined dangers to children in utero (such as the avoidance of certain foods or physical postures to avoid miscarriage) and the extensive and increasing use of midwives and the practice of giving birth in the homes. It will also be critical for students to develop knowledge and appreciation of the ethnic distinctive approaches to child rearing. This knowledge ranges from the different ways and times in which children are touched, fondled, held, and fed to the wide variety of sources beside biological parents, from which children derive security and affection, the utilization of nonlegal adoptive and foster care arrangements, the extensive use of and the concomitant impact of extended families – including godparents and compadres – plus the impact of their absence when families move to new communities. Students will require exposure to the ethnic-specific diseases (such as sickle cell anemia) or reactions which appear to be abnormal when taken out of context (such as ataque or the Puerto Rican syndrome), as well as the special vulnerability of ethnic individuals and communities to such diseases as high blood pressure, heart disease, cancer, alcoholism, and so forth, whose mortality rates are exceptionally or disproportionately high for this group.

About diseases regarding which much is known, the specific conceptualizations of ethnic minorities regarding causes, outcomes, and related health-seeking behaviors will have to be given serious consideration.

Attention will need to be given to how ethnic minority parents time and arrange for sex-specific experiences and assignments (such as males as emerging protectors of female siblings, approval of male sexual experimentation, preparation for expanding female roles, etc.), the specificity or lack of rites of passage (such as the celebration in some circles when Hispanic girls reach their 16th birthday) and the processes of mate selection. Currently we are beginning to appreciate how adults in general approach their major life roles of marriage, parenthood, and work.[26] The impingement of racism, discrimination, and curtailed opportunities that limit the accomplishment of these tasks by ethnic minority adults will require systematic knowledge development and teaching. In a related manner, while we are learning more about aging, we will need to learn and teach more regarding issues peculiar to minority aging, including the enormous social value attributed to aged parents and relatives, the ethnic-specific manner in which their physical and financial dependency are viewed and dealt with, and the relationship with younger relatives as role models, culture bearers, modulators of family strife, maintainers of contact with significant institutions, and providers of continuity.

Preparation for competent practice is the ultimate rationale for graduate social work education. Some of the related knowledge and many of the skills currently available and utilized in social work practice in general are transferable to the area of preventive practice, even as skills specific to this form of practice are generated and taught. So it is that students must be assisted in their coming to grips with the underutilization of established institutional services by minority individuals, the viability of the short-term crisis-oriented approaches and the manner in which existing professional attitudes affect all forms of practice with ethnic minority individuals and communities. Similarly, students must become acquainted with the developing knowledge regarding the styles and pace of self-disclosure by ethnic minority individuals, their utilization of nonverbal communication, and the skills requisite for supporting natural helping networks, reinforcing ethnic, ego-syntonic behaviors and attitudes, and enhancing empowerment in these communities.

Students and practitioners – beginning and established alike – have developed skills and extensive commitment to working directly with clients, or the hosts, in preventive terms. They would tend to find it easy to emphasize such related skills even when and if they attempt to engage in prevention. Their competence and potential success will be enhanced as they are able to distinguish those treatment skills which have distinctive preventive potential, such as the development of social competency, consciousness raising, and the improvement of problem-solving skills within individuals or groups directly. On the other hand, the skills that impact directly on the environment or the agent (such as potential disease-causing factors) will require more specific attention and elaboration and opportunities to develop competence during the educational endeavor. Difficult as it is to teach practice skills, the preparation for preventive practice will be even more difficult because of the temporary professional uncertainty or doubts about preventive practice. The skills in mental health consultation, in developing and maintaining social networks and in empowering individuals and communities, all offer considerable promise and will require increasing exposure to students and practitioners alike.

As has been suggested repeatedly, one of the major pressing needs is for the systematic evaluation of prevention practice. Given practitioners' antipathy toward and limited use of research, it will be incumbent on educators to stimulate their recognition of its utility and enhance their appreciation and participation in such efforts. The difficulty of evaluating whether problems have been prevented, how this has been accomplished, and the implications of professionals' participation cannot be overlooked in considering the entire question of prevention.

Conclusion

Prevention has been heralded as the fourth mental health revolution[27] and as an idea whose time has come.[28] Growing commitment to this perspective, a burgeoning literature and some mandatory legislation appear to support this view. But if the revolution has truly begun, the big guns or major battalions have not reached the battlefront. Rather, skirmishes represented by experimental programs abound, many with exceeding promise. The various authors in this monograph have identified some of these programs, made proposals for new ones or for changes in existing programs, and identified many of the current deficits. The major

current need is twofold – the integration and dissemination of existing knowledge for use by current and future practitioners, and the systematic evaluation of existing theories, approaches, and programs with particular emphasis on their implications for an applicability to the problems confronting ethnic minority individuals and communities. This latter task will be even more difficult than the previous effort of sufficiently interesting faculty, students, and practitioners in prevention in order to stimulate discussion and initiate courses. Now that that particular step has been taken it is impossible to turn back. Similarly, the increasing acuteness and breadth of problems confronting ethnic minority groups and communities will demand the maintenance and expansion of commitment and resources to eliminate existing and preventing future problems. The social work profession must be ready to make its contribution, provide leadership and prepare the necessary manpower.

Notes

1. Eli M. Bower, "Slicing the Mystique of Prevention with Occam's Razor," *American Journal of Public Health*, Vol. 59, (1969), pp. 478-84.
2. *Ibid.*
3. *Report to The President's Commission on Mental Health Prevention*, Vol. IV, (Washington, D.C.: U.S. Government Printing Office, 1978).
4. Samuel O. Miller, "Clinical Social Work in Cross-cultural Context" in *The Handbook of Clinical Social Work*, eds., Aaron Rosenblatt et al. (San Francisco: Jossey Bass, Inc., in press.
5. *Ibid.*
6. Bradley Buell, "Implications for Social Work Education of a Conception of Prevention," in *Proceedings: Education for Social Work, 1960 APM, Oklahoma City*, (New York: Council on Social Work Education, 1961). Note: Despite the positive reference noted here, Buell rejects the public health conception of prevention feeling that it is not applicable to social problems and social welfare's major responsibility. He doubts the potential for preventing the onset of these problems.
7. Martin Bloom, *Primary Prevention: The Possible Science*, (Englewood Cliffs, N.J.: Prentice Hall, 1981).
8. Helen Northen, *Clinical Social Work*, (New York: Columbia University Press, 1982.
9. June Brown, "Primary Prevention: A Concept When Time Has Come for Improving the Cultural Relevance of Family and Children's Services in Ethnic Minority Communities," (Draft for the monograph), p. 11.
10. Bloom, *op. cit.*
11. Miller, *op. cit.*
12. Ricardo F. Munoz, "The Primary Prevention of Psychological Problems", *Community Mental Health Review*, Vol. 1, No. 6 (1976), pp. 4-15.
13. See Bernard Bloom, "Prevention of Mental Disorder: Recent Advances in Theory and Practice", *Community Mental Health Journal*, Vol. 15, No. 3 (Fall 1979), pp. 171-91; also, Munoz, *op. cit.*
14. Bernard Bloom, *op. cit.*
15. See Alan Harwood, *Ethnicity and Medical Care*, (Cambridge, Mass.: Harvard University Press, 1981).
16. A. Y. Cohen, *Alternatives to Drug Abuse; Steps Toward Prevention* (Washington, D. C.: DHEW Pub. No. (ADM) 1975 pp. 75-79).
17. Dale M. DeWild, "Toward a Clarification of Primary Prevention," *Community Mental Health Journal*, Vol. 16, No. 4 (Winter, 1981) pp. 306-16.

18. Franklin Ranes and Frances Chiapetta, "Utilization of Older Americans in the Treatment of Child Abuse and Neglect," in *Removing Cultural Barriers in Health Care*, ed. Elizabeth Watkins and Audreye Johnson, (Durham, N.C.: University of North Carolina Press, 1979).
19. David Maldonado, "Prevention for the Minority Elderly" (Draft for this monograph).
20. Bernard Bloom, *op. cit.*; DeWild, *op. cit.*; and Munoz, *op. cit.*
21. *Task Panel Reports to the President's Commission on Mental Health*, Vol. III (Washington, D. C.: U. S. Government Printing Office, 1978).
22. DeWild, *op. cit.*; and Munoz, *op. cit.*
23. Miller, *op. cit.*
24. DeWild, *op. cit.*
25. Andrew Billingsley, *Black Families in White America*, (Englewood Cliffs, N.J.: Prentice Hall, 1968).
26. Helen Perlman, *Persona: Social Role and Personality*, (Chicago, Ill.: The University of Chicago, Press, 1968).
27. *President's Commission on Mental Health: Prevention Task Panel Reports*, Vol. VI., Washington, D. C.: U. S. Government Printing Office, 1978). pp. 1822-63.
28. D. C. Klein, and S. E. Goldston, eds. *Primary Prevention: An Idea Whose Time Has Come* (DHEW Publication, No. ADM 77-147, Washington, D.C.: U. S. Government Printing Office, 1977).